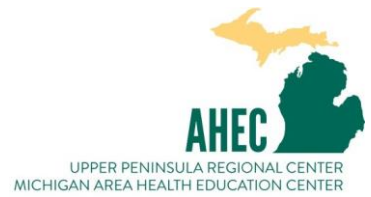




Student Experience Program Inquiry Form

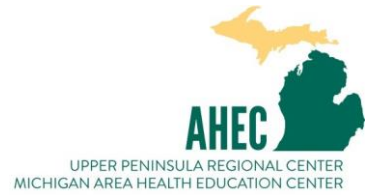


Last Name/First name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		Birthdate (mm/dd/yyyy)	
Address		City	State	Zip + 4	County
Primary Phone Number :		School Email Address:		Personal Email Address:	
Ethnicity (select one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		Veteran Status <input type="checkbox"/> <u>Active Duty Military</u> : An individual serving in a full-time capacity in one (1) of the seven (7) uniformed services. <input type="checkbox"/> <u>Reservist</u> : An individual serving in a part-time capacity in one (1) of the seven (7) uniformed services. <input type="checkbox"/> <u>Veteran</u> (Prior service): An individual discharged from one (1) of the seven (7) uniformed services after serving a period of 90 days or more. <input type="checkbox"/> <u>Veteran</u> (Retired): An individual discharged from one (1) of the seven (7) uniformed services after serving a period of 20 years or more OR An individual discharged from one (1) of the seven (7) uniformed services due to medical status. <input type="checkbox"/> <u>Individual is not a Veteran</u> : A student who has never served in one (1) of the seven (7) uniformed services OR An student who was discharged from one (1) of the seven (7) uniformed services before serving a total of 90 days or more. <input type="checkbox"/> Prefer not to disclose			
Race (select one) <input type="checkbox"/> African American / Black <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> More than one Race <input type="checkbox"/> Prefer not to disclose					
Can you answer yes to any of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> • You are (or will be) the first generation in your family to attend college. • You have or currently receive Scholarship or Loan for Disadvantaged Students. • While growing up, you or your family ever used federal or state assistance programs (such as: free or reduced school lunch, subsidized housing, food stamps, Medicaid etc.). • While growing up, you lived where there were few medical providers at a convenient distance. 					
In which kind of community did you grow up? (Select all that apply) <input type="checkbox"/> Medically Underserved Area <input type="checkbox"/> Rural (not a big city) <input type="checkbox"/> Urban					
In what school are you currently enrolled?		Are you in the education program (Select one) <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time		Anticipated Date of Graduation (mm/dd/yyyy) / /	
School Contact Name:		School Contact Phone Number:		School Contact Email:	
In what Specialty would you like to have your student experience? <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Dental <input type="checkbox"/> OB/GYN <input type="checkbox"/> Family Practice <input type="checkbox"/> Sports Medicine <input type="checkbox"/> Addiction Medicine <input type="checkbox"/> Pediatrics		Do you have a preceptor you would like to request? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name: _____ How many hours would you like to complete? _____ hours		What is your preferred schedule for your student experience? <input type="checkbox"/> Monday Time: _____ <input type="checkbox"/> Tuesday Time: _____ <input type="checkbox"/> Wednesday Time: _____ <input type="checkbox"/> Thursday Time: _____ <input type="checkbox"/> Friday Time: _____	
Rotation Start Date:		Rotation End Date:		<i>We will try to accommodate dependent upon preceptor availability.</i>	

Information for this form is provided voluntarily. AHEC is required to report information about program participants. Data will be kept private to the extent allowed by law and will be referenced periodically to evaluate the effectiveness of AHEC services and programs.



Student Experience Program Application



Educational Level You Are Currently In (Select one)		
<input type="checkbox"/> Undergraduate-Year 1 <input type="checkbox"/> Undergraduate-Year 2 <input type="checkbox"/> Undergraduate-Year 4 <input type="checkbox"/> Undergraduate-Year 3	<input type="checkbox"/> Graduate-Year 1 <input type="checkbox"/> Graduate-Year 2 <input type="checkbox"/> Graduate-Year 3 <input type="checkbox"/> Graduate-Year 4 <input type="checkbox"/> Graduate-Year 5 <input type="checkbox"/> Graduate-Year 6 <input type="checkbox"/> Graduate-Year 7	<input type="checkbox"/> Residency-Year 1 <input type="checkbox"/> Residency-Year 2 <input type="checkbox"/> Residency-Year 3 <input type="checkbox"/> Residency-Year 4 <input type="checkbox"/> Fellowship-Year 1 <input type="checkbox"/> Fellowship-Year 2
Degree You Are Currently Working Toward (Select one)		
<input type="checkbox"/> Student-Graduate Nursing <input type="checkbox"/> Student-Nurse Midwife <input type="checkbox"/> Student-NP-Acute Care Adult Gerontology <input type="checkbox"/> Student-NP-Acute Care Pediatrics <input type="checkbox"/> Student-NP-Adult <input type="checkbox"/> Student-NP-Family <input type="checkbox"/> Student-NP-Neonatal <input type="checkbox"/> Student-NP-Pediatrics	<input type="checkbox"/> Student-Graduate-Nursing Doctorate Specialty: _____ <input type="checkbox"/> Nursing-Licensed Practical/Vocational Nurse (LPN/LVN) <input type="checkbox"/> Student-NP-Psychiatric/Mental Health <input type="checkbox"/> Student-Alternative/Complementary Nursing <input type="checkbox"/> Student-Nursing-BS/BSN <input type="checkbox"/> Student-Certified Nursing Assistant <input type="checkbox"/> Student-Registered Nurse (RN)	<input type="checkbox"/> Student-NP-Other advanced nurse specialist <input type="checkbox"/> Undergraduate-Other Specify: _____ <input type="checkbox"/> Other Graduate School Specify: _____

In the future, I would like to work in a primary care setting (e.g. a clinic for Family Medicine, General Pediatrics).	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
In the future, I would like to enter a health career as a primary care clinician (e.g. Family Medicine, Pediatrics, General Dentistry, Nurse Practitioner, or Physician Assistant).	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
In the future, I would like to work with people who are medically underserved, that is people who face economic, cultural or linguistic barriers to healthcare.	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
In the future, I would like to work in rural areas, not big cities.	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	
Have you been an employee at Upper Great Lakes Family Health Center in the past?	Have you been a student or volunteer at Upper Great Lakes Family Health Center in the past?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the future, I would like to be employed by Upper Great Lakes Family Health Center?	Do you have a friend or relative who is or was employed with UGL in the past? If so, whom?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted or pled guilty to any crime (including but not limited to any traffic offense, petty offense, misdemeanor or felony)?	Are you currently under investigation or are there current charges against you for a felony?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please provide details on a separate sheet regarding date of conviction, offense for which you were convicted, the city, county and state in which you were convicted, and the sentence imposed on you. Disclosure of this information does not automatically exclude you from participation in the student experience program.	If yes, please provide details on a separate sheet regarding date of conviction, offense for which you were convicted, the city, county and state in which you were convicted, and the sentence imposed on you. Disclosure of this information does not automatically exclude you from participation in the student experience program.

Information for this form is provided voluntarily. AHEC is required to report information about program participants. Data will be kept private to the extent allowed by law and will be referenced periodically to evaluate the effectiveness of AHEC services and programs.



Student Experience Program Application



I understand that this inquiry form does not indicate my acceptance to the Upper Great Lakes Family Health Center Student Experience Program, nor does it indicate that I will be employed or paid by Upper Great Lakes Family Health Center.

Sign: _____ Date: _____

Thank you for your time in completing this form and your student experience packet.

Please return to:
upahec@uglhealth.org