



Please complete all relevant data and submit form. If you are unsure or unaware of the answer please leave blank. Questions? Call Texas AHEC East 409/772-7884

Resident/Student Data Worksheet (B100)

Today's Date:

AHEC Center:

Program Coordinator:

Information for this form is provided voluntarily. Texas AHEC East is required to report information about program participants. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.

<input type="checkbox"/> Dr. <input type="checkbox"/> Miss <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.		Last Name	First	M.I.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Current Address		City	State	ZIP Code	Primary Phone No.	Cell Phone No.
Permanent Address		City	State	ZIP Code	Permanent Phone No.	Pager/Other Phone No.
Institution Enrolled		Email Address		Number of dependents currently living with you (not including spouse/mate)		
Est. Date of Graduation		Ethnicity (select one)		Hispanic or Latino	Asian	
Education Level (already achieved) <input type="checkbox"/> AAS <input type="checkbox"/> DDS/DMD <input type="checkbox"/> MPH <input type="checkbox"/> AND <input type="checkbox"/> DO <input type="checkbox"/> MS <input type="checkbox"/> BA <input type="checkbox"/> EdD <input type="checkbox"/> MSN <input type="checkbox"/> BBA <input type="checkbox"/> MA <input type="checkbox"/> MSW <input type="checkbox"/> BE <input type="checkbox"/> MBA <input type="checkbox"/> PHD <input type="checkbox"/> BFA <input type="checkbox"/> MD <input type="checkbox"/> R.Ph. <input type="checkbox"/> BS <input type="checkbox"/> Med <input type="checkbox"/> BSN <input type="checkbox"/> MPA		<input type="checkbox"/> African American/Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White Disadvantaged <input type="checkbox"/> White Non-Disadvantaged <input type="checkbox"/> More than one race (specify) Primary _____ Secondary _____		<input type="checkbox"/> Central American <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> South American <input type="checkbox"/> Other _____	<input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Other _____	
Hometown at time of high school graduation (City/State)			College Attended (include City/State)		Undergraduate Major	
Is your hometown considered (select all that apply)				Are you fluent in any other Languages? (please specify)		
<input type="checkbox"/> Border Area <input type="checkbox"/> Rural <input type="checkbox"/> Inner City <input type="checkbox"/> Suburban <input type="checkbox"/> Urban				1. _____ <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write 2. _____ <input type="checkbox"/> Speak <input type="checkbox"/> Read <input type="checkbox"/> Write		
Student Type (select one)						
<input type="checkbox"/> Fellow <input type="checkbox"/> Student, Dental <input type="checkbox"/> Student, Nursing School <input type="checkbox"/> Intern <input type="checkbox"/> Student, Graduate Health Professions Program <input type="checkbox"/> Student, Pre-Health Professions College <input type="checkbox"/> Other _____ <input type="checkbox"/> Student, Medical School <input type="checkbox"/> Student, Undergraduate Health Professions Program <input type="checkbox"/> Resident						
Discipline (select one)						
<input type="checkbox"/> Assistants - Healthcare <input type="checkbox"/> Food and Nutrition Services <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Podiatric Med. – Primary Care <input type="checkbox"/> Chiropractic <input type="checkbox"/> Health Administration <input type="checkbox"/> Nursing–Other Advanced Practice <input type="checkbox"/> Pre-health Professional/ Undergrad. <input type="checkbox"/> Clinical Lab Services <input type="checkbox"/> Health Information/Education <input type="checkbox"/> Nursing–LVN <input type="checkbox"/> Preventive Medicine <input type="checkbox"/> Clinical Psychology <input type="checkbox"/> Medicine-Allopathic <input type="checkbox"/> Nursing–RN <input type="checkbox"/> Public Health <input type="checkbox"/> Community Health / Lay Health Worker <input type="checkbox"/> Medicine-Osteopathic <input type="checkbox"/> Nursing–Undergraduate <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Dental Hygienist <input type="checkbox"/> Mental Health <input type="checkbox"/> Other Allied Health <input type="checkbox"/> Social Work <input type="checkbox"/> Dental Public Health <input type="checkbox"/> Nurse Anesthetist <input type="checkbox"/> Pharmacy <input type="checkbox"/> Technicians & Technologists <input type="checkbox"/> Dentistry <input type="checkbox"/> Nurse Midwives <input type="checkbox"/> Physician Assistant						
Specialty (select one)						
<input type="checkbox"/> Dermatology <input type="checkbox"/> Internal Medicine–Infectious Disease <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pediatrics-Nephrology <input type="checkbox"/> Family Practice-Family Medicine <input type="checkbox"/> Internal Medicine-Nephrology <input type="checkbox"/> Pediatrics-Allergy <input type="checkbox"/> Pediatrics-Pulmonary <input type="checkbox"/> Family Practice-(CAM) <input type="checkbox"/> Internal Medicine-Pulmonary <input type="checkbox"/> Pediatrics-Cardiology <input type="checkbox"/> Pediatrics-Rheumatology <input type="checkbox"/> Internal Medicine-Allergy <input type="checkbox"/> Internal Medicine-Rheumatology <input type="checkbox"/> Pediatrics-Endocrinology <input type="checkbox"/> Psychiatry <input type="checkbox"/> Internal Medicine-Cardiology <input type="checkbox"/> Med / Peds <input type="checkbox"/> Pediatrics-Gastroenterology <input type="checkbox"/> Public Health <input type="checkbox"/> Internal Medicine-Endocrinology <input type="checkbox"/> Neurology <input type="checkbox"/> Pediatrics-General <input type="checkbox"/> Surgery-Cardiothoracic Surgery <input type="checkbox"/> Internal Medicine-Gastroenterology <input type="checkbox"/> OB / Gyn <input type="checkbox"/> Pediatrics-Genetics <input type="checkbox"/> Surgery-General <input type="checkbox"/> Internal Medicine-General <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Pediatrics-Hematology/Oncology <input type="checkbox"/> Surgery-Oncology <input type="checkbox"/> Internal Medicine-Geriatrics <input type="checkbox"/> Orthopedics <input type="checkbox"/> Pediatrics-Infectious Disease <input type="checkbox"/> Surgery-Oral & Maxillofacial <input type="checkbox"/> Internal Medicine–Hematology/ Oncology <input type="checkbox"/> Pediatrics-Neonatology <input type="checkbox"/> Surgery-Urology						
Did you obtain a NHSC (National Health Service Corp.) Scholarship?		What type of community would you like to locate for ultimate practice? (select all that apply)			Name any hobbies, special interests etc...	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No, but interested		<input type="checkbox"/> Border Area <input type="checkbox"/> Rural <input type="checkbox"/> Inner City <input type="checkbox"/> Suburban <input type="checkbox"/> Urban				

Check any services that you are requesting from AHEC (*some services may not be available at all centers*)

Housing Community Orientation Other

Were you informed by AHEC about a job opportunity in a training site community? Yes No

If so... Address

City

State

Zip

ROTATION INFORMATION (Must be completed in it's entirety)

Student Name

Start Date	End Date	Total Hours	Start Date	End Date	Total Hours
Course Name (i.e. POM, Clinical Fieldwork, Clinical Experiences II, etc...)			Course Name (i.e. POM, Clinical Fieldwork, Clinical Experiences II, etc...)		
Course Coordinator Name			Course Coordinator Name		
(1) Community Faculty Name			(2) Community Faculty Name		
Community Site Name			Community Site Name		
Housing Site Name			Housing Site Name		
Start Date	End Date	Total Hours	Start Date	End Date	Total Hours
Course Name (i.e. POM, Clinical Fieldwork, Clinical Experiences II, etc...)			Course Name (i.e. POM, Clinical Fieldwork, Clinical Experiences II, etc...)		
Course Coordinator Name			Course Coordinator Name		
(3) Community Faculty Name			(4) Community Faculty Name		
Community Site Name			Community Site Name		
Housing Site Name			Housing Site Name		