

CBET Student/Resident Worksheet

STUDENT INFORMATION:			Today's Date:		
Last Name/First name		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate (mm/dd/yyyy)	
Address		City	County (not USA)		State
Primary Phone #		Email Address:			
Race (select all that apply) <input type="checkbox"/> African American / Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Not reported		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. 			
Did you grow up in a rural or remote (geographically isolated) area? <input type="checkbox"/> Yes <input type="checkbox"/> No					
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"/> Not Reported					
AHEC Scholar? <input type="checkbox"/> Yes <input type="checkbox"/> No			Anticipated Date of Graduation (mm/yyyy):		
School:			Anticipated Date of Graduation (mm/yyyy):		
Type of Student/Trainee: <input type="checkbox"/> Resident <input type="checkbox"/> Student – Medical School <input type="checkbox"/> Student – Nursing School <input type="checkbox"/> Student – Dental School <input type="checkbox"/> Student – Graduate Health Professions Specify: _____ <input type="checkbox"/> Student - Undergraduate		Health Profession Discipline: <input type="checkbox"/> Medical School <input type="checkbox"/> Allopathic Medicine – MD <input type="checkbox"/> Osteopathic General Practice - DO <input type="checkbox"/> Nursing <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> NP—Specify _____		<input type="checkbox"/> Optometry <input type="checkbox"/> General Dentistry <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Pharmacy School <input type="checkbox"/> Resident—Specify Discipline & Specialty _____ <input type="checkbox"/> Other: _____	
After training, I plan to work (check all that apply): <input type="checkbox"/> In a primary care clinical setting <input type="checkbox"/> With underserved populations <input type="checkbox"/> In a rural area <input type="checkbox"/> None of these <input type="checkbox"/> Don't know					
CURRENT/PREVIOUS ROTATION INFORMATION: *** Please fill out all three boxes below with current, previous, or future rotation information					
Training Site: _____		Address: _____			
Preceptor: _____		Credential (MD, NP, PA ...): _____			
Dates: From: ___/___/_____ To: ___/___/_____		Preceptor's Email: _____			
Total Hours: _____		Rotation Type: _____			
PREVIOUS/FUTURE ROTATION INFORMATION:			PREVIOUS/FUTURE ROTATION INFORMATION:		
Training Site: _____			Training Site: _____		
Site Address: _____			Site Address: _____		
Preceptor: _____			Preceptor: _____		
Credential: _____			Credential: _____		
Dates: From: ___/___/_____ To: ___/___/_____ Total Hours: _____			Dates: From: ___/___/_____ To: ___/___/_____ Total Hours: _____		
Rotation Type: _____			Rotation Type: _____		
Preceptor's Email: _____			Preceptor's Email: _____		
If your rotation qualifies, would you like housing assistance or mileage reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No					

This section for office use:

EC NA SA SE WC

Entered: _____

(initials & date)