

**PENNSYLVANIA
AHEC**

**CLINICAL
EXPERIENCE
REPORTING FORM
(ENTRANCE)
CR - 1**

AHEC Region Use Only:

Code: _____

The Pennsylvania AHEC, in partnership with your school, is seeking to help meet the primary care needs of our communities and to make health careers training a more valuable experience. Results from this survey will be used to support these goals. **All survey responses are confidential.** Data will only be used within the AHEC program and never for commercial purposes.

Please answer each item as completely as possible. Please print all responses.

Date Completed: ____ / ____ / ____
Month Day Year

1. Name _____
Last Name

First Name Middle Name

2. What is your year of birth?

2a. What is the ZIP Code of where you lived for most of your high school years? _____

3. What is your gender?

- Male (1)
- Female (2)

4. What race or ethnicity best describes you?
(Check only one)

- Black/African American (1)
- White/Caucasian (2)
- Hispanic/Latino (3)
- Asian (4)
- American Indian or Alaskan Native (5)
- More than one race (6)
- Other _____ (7)

5. What is your current address?

Street _____

City _____

State _____ Zip _____

6. What is your permanent address?
(You may list the address of a relative or friend who will know your address after graduation.)

Name _____
Relationship _____
Street Address _____
City _____ State _____
Zip _____ Country _____

7. What is the name of your current school and program?

Name of School: _____
Name of Program: _____

8. What best describes the educational program in which you are currently enrolled?

- | | |
|--|--|
| <input type="checkbox"/> Medical School (1) | <input type="checkbox"/> Dental School (2) |
| <input type="checkbox"/> Dental Hygienist Program (3) | <input type="checkbox"/> Nursing RN Program (4) |
| <input type="checkbox"/> Nursing (ASN or Diploma RN) (5) | <input type="checkbox"/> Nursing-CRNP Program (6) |
| <input type="checkbox"/> Nursing-CNMW Program (7) | <input type="checkbox"/> Nursing-MSN (other adv. practice nursing) (8) |
| <input type="checkbox"/> Physician Assistant Program (9) | <input type="checkbox"/> Pharmacist School (10) |
| <input type="checkbox"/> Physical Therapist Program (11) | <input type="checkbox"/> Occupational Therapist Program (12) |
| <input type="checkbox"/> Other program (please specify) _____ (13) | |

9. What year of your program are you currently in?

- 1st (1)
 2nd (2)
 3rd (3)
 4th (4)
 Other (please specify) _____ (5)

10. Please indicate the extent to which you agree with the following statements. (Please answer all.)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. I plan to eventually practice in Pennsylvania	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. I plan to eventually practice in a rural area	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. I plan to eventually practice in an urban area	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. I plan to eventually practice in a medically underserved area	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Thank you!

AHEC Region Use Only
Date Entered: ___/___/___ Month Day Year
Entered by: _____