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.

Date Completed: ___/___/___

1. Your Name:
   Last Name: ___________________________ First Name: ___________________________
   Middle Name: ____________________ Maiden Name: _______________________

2. Academic/Training Year:
   - Undergraduate – Year 1 (1)
   - Undergraduate – Year 2 (2)
   - Undergraduate – Year 3 (3)
   - Undergraduate – Year 4 (4)
   - Undergraduate – Year 5 (5)
   - Graduate – Year 1 (9)
   - Graduate – Year 5 (10)
   - Graduate – Year 6 (11)
   - Graduate – Year 7 (12)
   - Residency – Year 1 (13)
   - Residency – Year 2 (14)
   - Residency – Year 3 (15)
   - Residency – Year 4 (16)
   - Fellowship – Year 1 (17)
   - Fellowship – Year 2 (18)
   - Fellowship – Year 3 (19)
   - Internship – Year 1 (20)
   - Internship – Year 2 (21)
   - Non-Degree Training Program – Year 1 (22)
   - Non-Degree Training Program – Year 2 (23)
   - Residency – Year 1 (21)
   - Residency – Year 2 (20)
   - Residency – Year 3 (19)
   - Residency – Year 4 (18)
   - Fellowship – Year 1 (17)
   - Fellowship – Year 2 (18)
   - Fellowship – Year 3 (19)
   - Internship – Year 1 (20)
   - Internship – Year 2 (21)
   - Non-Degree Training Program – Year 1 (22)
   - Non-Degree Training Program – Year 2 (23)

3. Training Category:
   - Student (Enrollee) (1)
   - Fellow (2)
   - Resident (3)
   - Faculty (4)
   - Practicing Professional (5)

4. Enrollment Status:
   - Full-Time (1)
   - Part-Time (2)
   - On leave of absence (3)

5. Age Group:
   - Under 20 years (1)
   - 20-29 years (2)
   - 30-39 years (3)
   - 40-49 years (4)
   - 50-59 years (5)
   - 60 years or older (6)

6. What is your discipline/specialty:
   - Chiropractic (1)
   - Family Medicine (2)
   - General Internal Medicine (3)
   - General Pediatrics (4)
   - General Preventive Medicine (5)
   - Obstetrics/Gynecology (6)
   - Pharmacy (7)
   - Podiatry (8)
   - Psychiatry (9)
   - Public Health (10)
   - Physician Assistant (11)
   - General Dentistry (12)
   - Dental Hygiene (13)
   - Dental Assistant (14)
   - Public Health Dentistry (15)
   - Nurse Administrator (16)
   - Nurse Anesthetist (17)
   - Nurse Midwife (18)
   - Nurse Practitioner (NP) (19)
   - LPN (20)
   - MSN – other adv. nurse specialists (21)
   - Registered Nurse (22)
   - Clinical Psychology (23)
   - Clinical Social Work (24)
   - Physical Therapy (25)
   - Other: ______________________________

7. What is the name of the facility where your rotation took place?
   Name of facility: ____________________________ Zip Code: __________
8. What is the name(s) of your preceptor(s) responsible for this rotation?

Preceptor Name: ___________________________ First ___________________________ Last ___________________________

Preceptor Name: ___________________________ First ___________________________ Last ___________________________

9. Was the clinical experience (rotation) you just completed labeled as (or could best be considered) which of the following?

☑ Family Medicine (1) ☐ OB/GYN (6)
☐ General Internal Medicine (2) ☐ General Dentistry (7)
☐ General Pediatrics (3) ☐ Nursing (8)
☐ General Surgery (4) ☐ Pharmacy (9)
☐ Psychiatry (5) ☐ Other: ___________________________

10. What were the start and end dates of this clinical experience (rotation)?

Start Date: _____ / _____ / _____ _____
End Date: _____ / _____ / _____ _____

11. How much clinical time did you spend in this training/clinical experience? (If less than 1 day enter “1”)

_____ _____ day(s)

12. Did you complete this program (rotation)? ☐ Yes ☐ No

13. Do you intend to practice in Pennsylvania? ☐ Yes ☐ No

Do you intend to practice in a Primary Care Setting? ☐ Yes ☐ No

Do you intend to practice in a Medically Underserved Area? ☐ Yes ☐ No

Do you intend to practice in a Rural Area? ☐ Yes ☐ No

14. Please rate the clinical experience (rotation) you just completed with respect to the following:

<table>
<thead>
<tr>
<th>Rating</th>
<th>Extremely Dissatisfied</th>
<th>Dissatisfied</th>
<th>Neutral</th>
<th>Satisfied</th>
<th>Extremely Satisfied</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Achievement of the learning objectives intended or stated for this experience</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>b.</td>
<td>Achievement of my personal learning objectives</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>c.</td>
<td>Accessibility of on-site learning resources (Internet, tutorials, etc.)</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>d.</td>
<td>Accessibility of preceptor</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>e.</td>
<td>Opportunity to deliver hands-on patient care</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
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<tr>
<td>f.</td>
<td>Accessibility of internet and other learning resources from my housing location</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>g.</td>
<td>Quality/condition/safety of housing</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>h.</td>
<td>Quality of community lifestyle (i.e. resources/culture/educational/social/entertainment)</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

AHEC Region Use Only

Date Entered: _____ / _____ / _____ _____
Preceptor Code: __ __ __ __ __ __

Site Code: __ __ __ __ __ __
Entered by: ___________________________