PENNSYLVANIA AHEC	RESIDENCY TRACKING FORM I RT-1	**AHEC Region Use Only:** Code: _ _ _ _ _ _ _ _ _ _

The Pennsylvania AHEC, in partnership with your medical 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 the name of your medical school?

   ____

3. What is the name of the hospital or health system at which your residency will take place?

   ____

4. What is the name of your residency program (e.g., family medicine or pediatrics)?

   ____

5. What is the address of your residency program? (Please complete as much as you can)

   ____
   Street Address

   ______________________________ ___ ___ ___ ___ ___ ___ ___
   City State Zip

6. What is the expected start date of your residency?

   ___ ___ / ___ ___ / ___ ___ ___ ___
   Month Day Year

7. What is the expected length of your residency?

   ____ years ___ ___ months

AHEC Region Use Only

Date Entered: __ __ / __ __ / __ __ __ __
Month Day Year

Entered by: ________________________

Thank you!

v2
3-17-10