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

Thank you!

v2 3-17-10