

# Rural Immersion Student Application 2019

<b>Last Name, First Name</b>		<b>Gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Birthdate (mm/dd/yyyy)</b> / /	
<b>Address</b>		<b>City</b>		<b>State</b>	<b>Zip Code</b>
<b>Primary Phone #</b>		<b>Current University Email Address:</b>			
		<b>Permanent (after completing school) Email Address:</b>			
<b>Ethnicity (select one)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino		<b>Are you a Veteran?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes			
<b>Race</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> More than one race		<b>If yes, please select one of the options below:</b> <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 (Prior service)</u> : 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 (Retired)</u> : 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.			
<b>Can you answer yes to any of the following?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
<ol style="list-style-type: none"> <li>1. You are (or will be) the first generation in your family to attend college.</li> <li>2. You have or currently receive Scholarship or Loan for Disadvantaged Students.</li> <li>3. While growing up, did you or your family ever use federal or state assistance programs? (E.g., free or reduced-price school meals, subsidized housing, Supplemental Nutrition Assistance Program [SNAP], Medicaid etc.)</li> <li>4. While growing up, did you live where there were few medical providers at a convenient distance?</li> </ol>					
<b>In which kind of community did you grow up?</b> (Select one) <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural					
<b>In what institution are you currently enrolled?</b>		<b>Are you enrolled:</b> (Select one) <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time		<b>Anticipated Date of Graduation</b> / (mm/yyyy)	
<b>Please select your education level:</b>					
<u>Undergraduate:</u> <input type="checkbox"/> Year 1 <input type="checkbox"/> Year 2 <input type="checkbox"/> Year 3 <input type="checkbox"/> Year 4 <input type="checkbox"/> Year 5		<u>Graduate:</u> <input type="checkbox"/> Year 1 <input type="checkbox"/> Year 2 <input type="checkbox"/> Year 3 <input type="checkbox"/> Year 4 <input type="checkbox"/> Year 5		<u>Residency:</u> <input type="checkbox"/> Residency Year 1 <input type="checkbox"/> Residency Year 2 <input type="checkbox"/> Residency Year 3	
<b>Health Profession Discipline:</b>					
<input type="checkbox"/> Community Health Worker <input type="checkbox"/> Dental School <input type="checkbox"/> Nursing – Graduate/CNS/NP – Specify specialty _____		<input type="checkbox"/> Nursing—Registered nurse (RN) <input type="checkbox"/> Medical School <input type="checkbox"/> Pharmacy <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Resident/Fellow: Specialty _____		<input type="checkbox"/> Social Work <input type="checkbox"/> Therapy – Occupational, Physical, Respiratory <input type="checkbox"/> Other (specify): _____	
<b>Please indicate which program you are participating in:</b>					
<input type="checkbox"/> Rural Immersion Program <input type="checkbox"/> Community Based Experiential Training <input type="checkbox"/> Migrant Farm Worker Clinic(s)		<input type="checkbox"/> AHEC Interprofessional Fellowship <input type="checkbox"/> Other (please specify): _____			
<b>I intend/plan/would like to work in a primary care setting (i.e., Family Medicine, General Internal Medicine, General Pediatrics, OB/GYN, General Dentistry, Community Pharmacy).</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided <input type="checkbox"/> Not Applicable					
<b>I intend/plan/would like to work with people who are medically underserved (people who face economic, cultural or linguistic barriers to healthcare).</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided <input type="checkbox"/> Not Applicable					
<b>I intend/plan/would like to work in rural areas.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided <input type="checkbox"/> Not Applicable					

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Please indicate any special areas of interest (for example, primary care, child health, etc...):

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What are your reasons for applying for the Summer Rural Immersion Program? (e.g. what do you hope to gain personally and professionally from this experience)

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Are you currently planning to practice in a rural community after your residency or fellowship training? If so, why? If not, why not?

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**Authorization and consent:**

I certify that the information provided is accurate. Health360 and its agents are given my permission to reproduce for publications, presentations, and internet use any photos taken at program functions. If I choose to withdraw my permission, I must provide written notification.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_