HEALTH PROFESSION RURAL SUMMER IMMERSION PROGRAM

SUMMER 2019 APPLICATION

BACKGROUND

Last Name ___________________________________________ First Name ___________________________________________

Gender  □ Male  □ Female

Birth Date  (mm/dd/yyyy) ___________________________________________

Address ___________________________________________ City ___________ State _______ Zip Code ___________

Primary Phone # ___________________________________________ Current University Email Address ___________________________

Other Email Address(es) ___________________________________________

ETHNICITY (Select one)

□ Hispanic/Latino  □ Non-Hispanic/Non-Latino

RACE

□ American Indian or Alaska Native  □ Black or African American  □ White

□ Asian  □ Native Hawaiian or Pacific Islander  □ More than one race

ARE YOU A VETERAN?

□ No  □ Yes

If yes, please select one of the following options:

□ Active Duty Military: An individual serving in a full-time capacity in one (1) of the seven (7) uniformed services.

□ Reservist: An individual serving in a part-time capacity in one (1) of the seven (7) uniformed services.

□ Veteran (Prior service): An individual discharged from one (1) of the seven (7) uniformed services after serving a period of 90 days or more.

□ Veteran (Retired): a) An individual discharged from one (1) of the seven (7) uniformed services after serving a period of 20 years or more; or b) an individual discharged from one (1) of the seven (7) uniformed services due to medical status.

CAN YOU ANSWER YES TO ANY OF THE FOLLOWING? Please check all that apply.

□ Will you be the first generation in your family to attend college?

□ Do you have or currently receive Scholarship(s) or Loan(s) for Disadvantaged Students?

□ 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.)?

□ While growing up, did you live in a medically underserved area with few conveniently-located health care providers?

IN WHICH KIND OF COMMUNITY DID YOU GROW UP? (Select one)

□ Urban  □ Suburban  □ Rural
In what institution are you currently enrolled? ________________________________

Are you enrolled? (Select one) □ Part Time □ Full Time Anticipated Date of Graduation (mm/yyyy) ________________________________

### PLEASE SELECT YOUR EDUCATION LEVEL

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<thead>
<tr>
<th>Undergraduate</th>
<th>Graduate</th>
<th>Residency</th>
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<td>Year 1</td>
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### HEALTH PROFESSION DISCIPLINE

□ Community Health Worker
□ Dental School
□ Nursing Graduate/CNS/NP: Specialty __________________________
□ Nursing – Registered Nurse (RN)
□ Medical School
□ Pharmacy
□ Physician Assistant
□ Resident/Fellow: Specialty __________________________
□ Social Work
□ Therapy – Occupational, Physical, Respiratory
□ Other (specify): __________________________

### PLEASE INDICATE WHICH PROGRAM YOU ARE PARTICIPATING IN

□ Rural Immersion Program
□ Community-Based Experiential Training
□ Migrant Farm Worker Clinics
□ AHEC Interprofessional Fellowship
□ Other (please specify): __________________________

I intend/plan/would like to work in a primary care setting (e.g., family medicine, general internal medicine, general pediatrics, OB/GYN, general dentistry, community pharmacy).
□ Yes □ No □ Undecided □ Not applicable

I intend/plan/would like to work with people who are medically underserved (i.e., people who face economic, cultural or linguistic barriers to health care).
□ Yes □ No □ Undecided □ Not applicable

I intend/plan/would like to work in rural areas.
□ Yes □ No □ Undecided □ Not applicable
Please indicate any special areas of interest (e.g., primary care, child health, etc.):

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What are your reasons for applying for the HPRSIP (i.e., 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? Why or why not?

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Authorization and consent:
I certify that the information provided is accurate. Health360 and its agents have my permission to reproduce any photographs taken at HPRSIP functions for publications, presentations, internet and social media use. If I choose to withdraw my permission, I must provide written notification before the conclusion of the program.

Signature ___________________________________________ Date ________________