



- Rotation
- Shadow

**NWAHEC FACT SHEET**  
**NORTHWEST AREA HEALTH**  
**EDUCATION CENTER**  
 2215 Portland Ave, Suite 326.  
 Louisville, Kentucky 40212

Office Use Only. Database Entered Date _____ Initials _____
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<p><b>PERSONAL INFORMATION</b></p> <p>1. Student ID: _____</p> <p>2. Name: _____</p> <p>3. SSN Last 4 Digits: _____</p> <p>4. Date of Birth: _____</p> <p>5. E-mail: _____</p> <p>6. Cell phone: _____</p> <p>7. Home Phone: _____</p> <p>8. Address: _____</p> <p>9. City: _____</p> <p>10. State, Zip Code: _____</p>	<p><b>ACADEMIC INFORMATION</b></p> <p><b>11. School/University/College</b> _____</p> <p><b>12. College enrolled</b></p> <p><input type="checkbox"/> Health Sciences <input type="checkbox"/> Nursing  <input type="checkbox"/> Dentistry <input type="checkbox"/> Pharmacy  <input type="checkbox"/> Medicine <input type="checkbox"/> Other</p> <p><b>13. Discipline:</b> _____</p> <p><b>14. Anticipated Graduation date:</b> _____</p> <p><b>15. School status and program year</b></p> <p>High School <input type="checkbox"/>1 <input type="checkbox"/>2 <input type="checkbox"/>3 <input type="checkbox"/>4 <input type="checkbox"/>5        Undergraduate: <input type="checkbox"/>1 <input type="checkbox"/>2 <input type="checkbox"/>3 <input type="checkbox"/>4 <input type="checkbox"/>5        Graduate <input type="checkbox"/>1 <input type="checkbox"/>2 <input type="checkbox"/>3 <input type="checkbox"/>4 <input type="checkbox"/>5        Resident <input type="checkbox"/>1 <input type="checkbox"/>2 <input type="checkbox"/>3 <input type="checkbox"/>4 <input type="checkbox"/>5</p>	<p><b>STATISTICAL INFORMATION</b></p> <p><b>16. Ethnicity:</b> <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Hispanic</p> <p><b>17. Race:</b></p> <p><input type="checkbox"/> White <input type="checkbox"/> Asian (Underrepresented)* <input type="checkbox"/> Multiple Race  <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander  <i>* Any Asian other than Chinese, Japanese, Korean, Asian Indian or Thai.</i></p> <p><b>18. Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><b>19. Marital Status:</b></p> <p><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed</p> <p><b>20. Family Address:</b> _____        City: _____ State: _____ Zip Code: _____</p> <p><b>21. Year of Graduation from High School:</b> _____</p> <p><b>22. Veteran Status:</b> <input type="checkbox"/> Active Duty Military <input type="checkbox"/> Reservist  <input type="checkbox"/> Veteran – Prior Service <input type="checkbox"/> Veteran – Retired <input type="checkbox"/> Not a Veteran</p>
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**POST GRADUATION INTENT**

23. I intend to become employed or pursue further training in (check all that apply):  
 a primary care setting  a rural setting  a medically underserved community  none of the above  N/A

**ROTATION INFORMATION**

Rotation Site	Begin date	End Date	Total Hours	Preceptor	City/Town	Need Housing

**24. Please sign and date the Fact Sheet:**

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