

## WMT-AHEC STUDENT APPLICATION FOR CLINICAL ROTATION TRAVEL SUPPORT

(PLEASE PRINT)

Today's Date:			
STUDENT INFORMATION			
First name:		Last name:	
UM/MSU ID Number:		Preferred Email Address Currently:	
Birth date:	Age:	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Permanent (after completing school) Email Address:
Street address:		City:	State: ZIP Code:
Primary phone no.:		Ethnicity (select one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Race (select one):			
<input type="checkbox"/> African American/Black		<input type="checkbox"/> Asian (Other)	
<input type="checkbox"/> American Indian/Alaskan Native		<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	
<input type="checkbox"/> Asian (Chinese, Filipino, Japanese, Korean, Asian Indian, Thai)		<input type="checkbox"/> White	
<input type="checkbox"/> More than one Race Would you consider yourself "disadvantaged" (using the definition provided)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>A "disadvantaged" individual is one who comes from an environment that has inhibited the individual from obtaining knowledge, skills, and abilities required to enroll in and graduate from a health professional training school, or from a program providing education or training in an allied health profession OR a "disadvantaged" individual comes from a family with an annual income below a level based on low-income thresholds set by the US government.</i>			
Where did you grow up? (Please list city, state and county if known)			

SCHOOL/PROGRAM INFORMATION			
In what institution are you currently enrolled?	Are you in the education program (select one): <input type="checkbox"/> Part time <input type="checkbox"/> Full time		Anticipated Date of Graduation: / / (mm/yyyy)
Currently in which Educational Level: (select one)	<input type="checkbox"/> Pre-matriculation/pre-graduate school <input type="checkbox"/> Masters (MHA, MS, MSN, MSW, MPH, MSPH) <input type="checkbox"/> Post-Masters Certificate <input type="checkbox"/> Doctorate (PhD, DNP, DNSc, DC, DPT) <input type="checkbox"/> Post-Doctorate <input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Faculty Member <input type="checkbox"/> Post-graduate		<input type="checkbox"/> Medicine Doctor (MD) <input type="checkbox"/> Doctor of Osteopathy (DO) <input type="checkbox"/> Doctor of Dental Surgery (DDS, DMD) <input type="checkbox"/> Doctor of Pharmacy (PharmD) <input type="checkbox"/> Doctor of Veterinary Medicine (DVM, VMD) <input type="checkbox"/> Doctor of Psychology (PsyD) <input type="checkbox"/> Doctor of Public Health (DrPH) <input type="checkbox"/> ScD (Doctor of Science) <input type="checkbox"/> Adult learner <input type="checkbox"/> Dislocated Worker <input type="checkbox"/> Other (specify)
Health Profession Discipline: (Select one and specify below)	<input type="checkbox"/> Veterinary Medicine <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Nurse Midwife <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Dental Assistant <input type="checkbox"/> Dental Hygiene <input type="checkbox"/> General Dentistry	<input type="checkbox"/> Nutrition/Dietetics <input type="checkbox"/> Clinical Psychology <input type="checkbox"/> Clinical Social Worker <input type="checkbox"/> Substance Abuse/Addictions Counseling <input type="checkbox"/> Community Health Worker <input type="checkbox"/> Health Education/Behavior <input type="checkbox"/> Health Services/Hosp. Admin.	<input type="checkbox"/> Public Health <input type="checkbox"/> Clinical Lab Worker <input type="checkbox"/> EMT/Paramedics/1 <sup>st</sup> Responder <input type="checkbox"/> Health Information Systems/ Data Analysis <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other (specify below)
Please further specify discipline/specialty/subspecialty: _____			
Academic Course Coordinator Name:	Academic Course Coordinator Phone:	Academic Course Coordinator email:	

**ROTATION INFORMATION**

Rotation Course Dates:		Total Hours:
Start:     /     /     (mm/dd/yyyy)	End:       /     /     (mm/dd/yyyy)	
Description of Rotation/Course:		
Rotation/Course Code: _____		Rotation/Course Name: _____
Training Objective/Description: _____		
Training Site/Facility:		
Name: _____		
City/Town: _____		
Faculty/Contact Person at Training Site:		
Name: _____		Phone: _____ Email: _____
Housing Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Housing site name: _____
Round Trip Mileage from home campus: _____	Anticipated number of round trips: _____	

**INTENT TO PRACTICE**

I intend/plan/would like to work in a primary care setting, for example a clinic for Family Medicine, General Internal Medicine, or General Pediatrics? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
I intend/plan/would like to enter a health career as a primary care clinician (for example Family Medicine doctor, General Internal Medicine, General Pediatrics doctor, nurse practitioner, or physician assistant, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
I intend/plan/would like to work with people who are medically underserved, that is people who face economic, cultural, or linguistic barriers to healthcare? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
I intend/plan/would like to work in rural areas (not big cities)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable

**Please read and sign below to indicate your understanding of the limitations and requirements of AHEC travel support.**

The Western Montana Area Health Education Center (WMT-AHEC) works to improve the supply and distribution of healthcare providers in rural and underserved areas of Montana. As part of this effort, WMT-AHEC **may** be able to provide travel support for health professions students in rural and underserved clinical rotations. Support is limited by both by the funding available and by the following conditions:

- Participating undergraduate students must be in their senior or junior year.
- Rotations must take place at Critical Access Hospitals, Rural Health Clinics, Community Health Centers, or Indian Health Services.
- Funds are disbursed after the student submits a mileage record upon completion of the rotation, a follow-up survey, AND a one-page essay describing their experience.
- Participating students agree to respond to brief contacts (<1 per year) tracking their progress and location of practice.

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*Signature**Date*

**Please Return form to:**   Ilsa Seib  
 Administrative Associate  
 Western Montana Area Health Education Center  
 The University of Montana  
 32 Campus Drive, Skaggs Bldg. Rm. 173  
 Missoula, MT 59812

**Questions? Call Ilsa at 406-243-4746**