Mississippi Area Health Education Center

University of Mississippi Medical Center
Community Rotation Information Sheet

Please complete the entire form with signature at least four weeks prior to the beginning date of the rotation.

1. Name_____
2. Email_____
3. Student ID #_____
4. S.S. #_____
5. Date of Birth_____
6. Sex ☐ Male ☐ Female

7. Marital Status ☐ Single ☐ Married ☐ Other
8. Number of children_____
9. Ethnic Background

   ☐ American Indian ☐ Asian ☐ Black
   ☐ White ☐ Hispanic ☐ Other

10. Phone ( )_____
    Cell ( )_____
11. Current Address
    Street _____
    City _____
    State _____Zip_____

12. School in which enrolled

    ☐ Medicine ☐ Dentistry
    ☐ Nursing ☐ Allied Health

13. Program Year (Circle One)

Undergraduate	1	2	3	4
Graduate	1	2	3	4
Resident	1	2	3	4

14. Graduation Date (or completion of residency)

    _____/_____
    Month Year

15. Family residence at time of high school graduation
    City_____
    County_____
    State_____Zip_____

16. Approximate population of #15

    ☐ under 1,000 ☐ 25,000-49,999
    ☐ 1,000-9,999 ☐ 50,000-99,999
    ☐ 10,000-24,999 ☐ 100,000 & above

17. **Description of rotation**
    Department _____
    Course Name _____Required_____or Elective_____
    Dates of Rotation _____
    Number of Weeks _____
    Name of Preceptor _____
    Hospital / Clinic _____
    City of Rotation _____County_____
    Departmental Coordinator Approval _____

18. Housing Arrangements (check all applicable) ☐ Smoking ☐ Non-Smoking ☐ Pet Allergies

    ☐ I want AHEC to help arrange housing
    ☐ I will arrange my own housing
    ☐ I will need AHEC rent supplement
    ☐ I will stay with my family or friends-no rent
    ☐ I will commute (no travel allowance)

19. Date and time or arrival at rotation site Date_____/_____/____ Approximate Hour_____AM or PM (circle one)

20. Where you can be reached while on rotation Address_____Town_____Phone_____

21. Signature_____Date_____
    (Student)

22. Signature_____Date_____
    (Parent/Guardian – if applicable)