



# Mississippi Area Health Education Center

University of Mississippi Medical Center  
Information Sheet for Continuing Education

Please complete the entire form with signature prior to the continuing education program

1. Name \_\_\_\_\_

2. Email \_\_\_\_\_

3. S.S. # \_\_\_\_\_

4. Date of Birth \_\_\_\_\_

5. Sex  Male  Female

6. Marital Status  Single  Married  Other

7. Number of children \_\_\_\_\_

8. Ethnic Background

American Indian  Asian  Black

White  Hispanic  Other

9. Office phone ( ) \_\_\_\_\_

Cell phone ( ) \_\_\_\_\_

10. Current Work Address

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

11. Career

Medicine  Dentistry

Nursing  Allied Health

12. School completed (Circle highest level achieved)

Undergraduate 1 2 3 4

Graduate 1 2 3 4

Resident 1 2 3 4

13. Approximate population of place of work

under 1,000  25,000-49,999

1,000-9,999  50,000-99,999

10,000-24,999  100,000 & above

14. Provide an address and phone number where you can be reached while on attending C.E. course.

\_\_\_\_\_ ( ) \_\_\_\_\_  
Street Address Town Phone

15. Sign and Date

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Student)

16. Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian – if applicable)