HEALTH CAREERS PARTICIPANT PROFILE FORM

Please Legibly Write-In or Check Appropriate Box Below. Thank you!

Today's Program: _____ Today's Date: _____

PARTICIPANT INFORMATION

Last Name: _____ **First Name**: _____

Date of Birth: _____ **Gender:** F ☐ M ☐ **Age**: _____

Race/Ethnicity: ☐ African-American ☐ Caucasian ☐ American Indian

☐ Hispanic/Latino ☐ Asian ☐ Other_____

Current Mailing Address (Street, City, State and Zip Code): _____

_____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Name of School You Attend: _____

School Address (City and State ONLY): _____

Grade Level: ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Technical School ☐ College

If in technical school or college, what is your classification: _____

Anticipated Graduation Date: _____

Have you ever participated in an AHEC Program or Activity? ☐ Yes ☐ No

If "Yes", please provide name of program/activity and date(s) you attended):_____

_____

Do you plan to pursue a health career in your future? ☐Yes ☐No

If YES, which health career? _____

Participant Signature: _____ **Date:** _____

Please submit completed form to Health Careers Coordinator, Mr. Kedrick Williams.

The information provided is required by SPCC Atlanta AHEC funding sources and is used for statistical purposes only. The information will be kept strictly confidential. We thank you for your cooperation in completing this form.

Serving Fulton, DeKalb and Clayton counties with ♥!

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