
**HEALTH CAREERS AND WORKFORCE DIVERSITY**

**Registration Form**

**Information for this form is provided voluntarily. AHEC is required to report information about program participants. Data will be kept private to the extent allowed by law and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.**

**PROGRAM INFORMATION:**

**Title:**_____ **Registration Fee:**_____

**STUDENT INFORMATION:**

_____

**Student Name: First MI Last**

_____|_____|____|_____|_____

**Mailing address City State Zip Code County**

**SS# (last four digits):** ___|___|___|___ **Student Email:** _____

**Home Phone #:** _____ **Cell or Other contact #:** _____

**Current Grade:** _____ **School Name:** _____

**Graduation Year:** _____ **Gender:** ☐ **Male** ☐ **Female** **Date of Birth:** _____/_____/_____

**Race (check one):**

☐ American Indian or Alaskan Native
☐ African American/Black
☐ White
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ More Than One Race

**Ethnicity: (check one):**

☐ Hispanic
☐ Non Hispanic

**Student T-Shirt Size:** _____

**Student Career Interest(s):**

_____

_____

**PARENT/GUARDIAN(S) INFORMATION:**

_____

**Parent/Guardian(s) Name:**

_____|_____|___|_____|_____

**Mailing Address (If different from above) City State Zip Code County**

_____|_____|_____

**Parent/Guardian(s) contact phone Parent/Guardian(s) Work Phone Parent/Guardian(s) E-mail**