



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 _____