Area L AHEC
Part of the NC AHEC Program
Bridging Education to Quality in Health Care

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 INFORAMTION:

Title: _____ **Registration Fee:** _____
(Write in title of program) (If applicable)

STUDENT INFORMATION:

_____
Student Name: First MI Last

_____|_____|_NC_|_____|_____
Mailing address City State Zip Code County

4 digit code: ___|___|___|___ **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 Career Interest(s):

_____

PARENT/GUARDIAN(S) INFORMATION:

_____
Parent/Guardian(s) Name:

_____|_____|_NC_|_____|_____
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**