AHEC SCHOLARS PROGRAM

The AHEC Scholars program is designed to give currently enrolled health professions students additional training and team-based clinical experiences with health care providers in rural and underserved areas.

AHEC Scholars program benefits...

Students selected to participate in this 2 year training program will develop high quality, job readiness health care skills through intense inter professional collaborations with various health care disciplines.

ADDITIONAL BENEFITS INCLUDE:

- **Hands on experience working with medically trained health professionals from diverse backgrounds**
- **Earn an additional 40 hours of didactic training and 40 hours of clinical training above required health professions curricula**
- **Expanded knowledge about rural and community based care while working with underserved populations**
- **Open to all disciplines that support primary health care services delivery**

Requirements for Participation

- **Completed application**
- **Must have transportation this program includes training workshops at various rural sites (60 mile radius)**
- **Be a full time student in a college or university**
- **Must pass a criminal background check**
- **Must be willing to sign a 2 year participant**

BAYOU NORTH AREA HEALTH EDUCATION CENTER

LSU Health SHREVEPORT

CENTRAL LOUISIANA AHEC

AHEC SCHOLARS

APPLICATION

Demographic Information:

Social Security #:_____-_____-_____ **Date of Birth** _____/_____/_____ **Gender :** **Male** ☐ **Female** ☐

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

Ethnicity: ☐**Afr. American** ☐ **Am. Indian** ☐ **Asian** ☐ **Caucasian (White)** ☐**Hispanic Other:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip :**_____

Home Parish: _____**Home Phone :** (_____)_____-_____ **Student Cell Phone:** (_____)_____-_____

Student Email: _____

College or University: _____ **Projected College Graduation:** _____

School Address: _____ **City:** _____ **State:** _____ **Zip :**_____

Cumulative GPA (must be at least a 3.0): _____

Major _____**Minor** _____

College Activities/Honors: _____

_____

Do you prior experience working with rural healthcare professionals: **Yes** ☐ **No** ☐

Do you have a reliable transportation? **Yes**☐**No** ☐

Can we complete a criminal background check? **Yes** ☐ **No** ☐

Desired Health Career:

☐ **Medicine** ☐ **Dentistry** ☐ **Pharmacy** ☐**Physical Therapy** ☐ **Occupational Therapy**

☐ **Nursing** ☐ **Physician Assistant** ☐ **Radiologic Technology** ☐**Clinical Laboratory Technology**

I have answered all of the information on this application truthfully, and to the best of my knowledge.

Signature _____ **Date** _____

LSU Health SHREVEPORT™

Mail/Email your completed application to:

LSU Health Shreveport AHEC Program Office
1501 Kings Highway, Rm. 5 306
Shreveport, LA 71103

shvahec@lsuhsc.edu

318 675 8963 Voice; 318 675 5081 Fax

AHEC SCHOLARS

PARTICIPANT AGREEMENT

I, _____, hereby acknowledge my interest in and commitment to the AHEC Scholars Program. I understand the expectations of this program include maintaining a high standard of academic achievement and attending various seminars, workshops and other activities over a 2 year period plus a 1 year follow up period.

I agree to participate in 40 hours of didactic education and 40 hours of clinical training over a 2 year training period in a rural and underserved healthcare setting under the supervision of trained professionals.

I agree that I will abide by all rules regarding authorized and unauthorized areas of LSU Health Shreveport and Ochsner-LSU Health Shreveport. As guests in the facility, all participants must follow the assigned program schedule. I understand a professional and respectful attitude is required at all times.

_____ I agree to hold harmless and indemnify LSU Health and Ochsner—LSU Health Shreveport for personal injuries or illnesses that may occur while I am on the premises or traveling to the program as a participant.

_____ I agree to the use of my photograph or videotape of me for use in promotional or educational materials for AHEC programs.

_____ I understand the rules for confidentiality about patient information and that any breach of this confidentiality is unethical, illegal, and could result in punishment by law.

_____ I have completed/provided the requested medical information.

Student's Signature ***Date***

LSU Health SHREVEPORT™

AHEC SCHOLARS

EMERGENCY INFORMATION AND AUTHORIZATION FOR MEDICAL TREATMENT

Student Name _____ Age _____

Address _____

City_____State _____ Zip _____Phone # _____

Other Emergency Contact _____ Phone # _____

Medical Information *(Please indicate below if the condition is present or recurring)*

_____	DIABETES	_____	ASTHMA	_____	HEART CONDITION
_____	HEMOPHILIAC	_____	HEARING AID	_____	WEARS GLASSES/ CONTACTS
_____	NEURO/MUSCULAR PROBLEM	_____	ALLERGY	_____	OTHER

If any are checked, please explain _____

_____

Is student on any type of medication? ☐ yes ☐ no If yes, what type and dosage? _____

_____

Insurance Information

Insurance Company_____ Policy #_____

Primary Care Physician _____ Phone #_____

In case of an accident or serious illness, I hereby authorize hospital officials to make whatever arrangements necessary and to contact me immediately. I understand that it remains my responsibility to make any future information changes on this medical form as the need arises, by contacting LSU Health AHEC Program Office. Otherwise, this authorization will remain in effect, as of this date, until program completion. Neither LSU Health Shreveport nor Ochsner-LSU Health Shreveport assume responsibility for any medical charges.

Student Signature *Date*