



Student Demographic/Participation Form

First Name: _____ Middle Name: _____ Last Name: _____ Nickname: _____

Health Center/Clinical Site: _____

Clinical Rotation Type: _____ Hours Precepted: _____

School: _____ School State: _____

Discipline or Program: _____

State of Legal Residence (permanent address): _____

Birthdate: _____ Age: _____ Gender: _____

Personal E-mail: _____ Phone: _____

Select one of the following-Ethnic Categories	Check One
Hispanic or Latino	<input type="checkbox"/>
<u>Not</u> -Hispanic or Latino	<input type="checkbox"/>
Select all that apply -Racial Categories	Check all that apply:
American Indian or Alaska Native	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>
Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>
White	<input type="checkbox"/>
<u>Other</u> (check "other" for any racial category that is not identified in one of the five single race categories listed above)	<input type="checkbox"/>

Birthplace/City & State: _____

In which type of community did you grow up? (Select one) Rural Urban Suburban

The Ohio Primary Care Workforce Initiative (OPCWI) provides financial support to participating Federally Qualified Health Centers (FQHCs) which helps provide students the opportunity to learn in community settings. To evaluate the effectiveness of OPCWI we will contact you in the future to ask about your employment decisions. If you do not want to participate in the evaluation, you may opt-out by contacting Marie Grady at mgrady@ohiochc.org.

Administered by the Ohio Association of Community Health Centers, the Ohio Primary Care Workforce Initiative is funded in partnership by the Ohio General Assembly and the Ohio Department of Health. For more information please visit www.ohiochc.org/opcwi

Thank you for your participation!