OHIO PRIMARY CARE WORKFORCE INITIATIVE

DENTAL
MEDICAL
BEHAVIORAL HEALTH
PHYSICIAN ASSISTANT
ADVANCED NURSE PRACTITIONER
FQHC OACHC

Student Demographic Form

FQHC Primary Care Workforce Initiative

Student Name: ____________________

Health Center/Clinical Site: ____________________

Clinical Rotation Type: ____________________ Hours Precepted: __________

School: ____________________ School State: __________

Discipline or Program: ____________________

State of Legal Residence (permanent address): ____________________

Birthdate: __________ Age: __________ Gender: __________

E-mail: ____________________ Phone: ____________________

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

Birthplace/City & State: ____________________

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

At which school did you obtain your undergraduate degree? ____________________

What was your program of study and degree? ____________________

Thank you for your participation!

STUDY CONSENT FORM

What is the study about?

You are being invited to participate in an ongoing study conducted by the Ohio Association of Community Health Centers related to your medical school rotation at an Ohio community health center. The purpose of this study is to determine whether this rotation had an effect on your decision in selecting a medical specialty, the geographic location of your practice and the types of patients you accept in your practice.

What will participation involve?

You are being asked to complete a questionnaire and to complete several follow-up questionnaires that may extend over a number of years. Each questionnaire will take about 10- 20 minutes to complete each time. The questionnaires contain questions on a broad range of topics related to your demographic background, education and current and future career in the medical field. Your participation is completely voluntary. If you decide not to participate, you can stop at any time you wish or skip any question you choose without consequences of any kind.

How will the study be conducted?

Our initial contact with you may be by mail, email, phone, or in person, and all subsequent questionnaires will be conducted by mail, email, or phone. But signing this consent form, you are agreeing to allow us to contact you by these means. If you change your mind in the future, let us know, and we will no longer contact you by that method.

How will your data be protected?

The records of this study will be kept confidential, and digital data will be stored in secured computer files after it is entered. Any report of this research that is made available to the public will not include your name or any other individual information by which you could be identified. If you would like to access or change your answers to any of the questions, you may do so at any time by contacting the Ohio Association of Community Health Centers at 614-884-3101 or by email at info@ohiochc.org.

I have read the above information, and have received answers to any questions. I affirm that I am 18 years of age or older. I consent to take part in the research study.

____________________	____________________	__________
Printed Name	Signature	Date

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