MU-AHEC Summer Community Program – Summer 2018

Participation Confirmation Form

Please return this form via email or fax to:
Allison Fuemmeler, Program Coordinator

Fax: 573-884-2349 Email: fuemmeleran@health.missouri.edu

Institution Name: _____

Number of Students we will sponsor: _____

Length of Program *(*Please indicate which length of time you prefer*):

_☐_ 4 weeks, scholarship payment of $1,052.63 per student
_☐_ 6 weeks, scholarship payment of $1,578.95 per student

☐ **Yes, we will pay the scholarship per the amounts above.**

☐ ***We are unable to participate at this time*.**

Authorizer Name *(please print)*: _____**Title:** _____

Signature: _____**Date:**_____

Phone: _____ **Email:** _____

***June 4th is** the anticipated date that the student will be available to begin the program, but dates are flexible, depending upon physicians' and students' schedules*.

HOUSING

☐ **Yes, we will be able to provide housing for the student (if needed)**

☐ **No, we will not be able to provide housing for the student**

Type of Housing Available:

☐ **Private Hospital Room**
☐ **Apartment (single)**
☐ **Apartment (shared, single sex)**
☐ **Apartment (shared, co-ed)**
☐ **House (shared, single sex)**
☐ **House (shared, co-ed)**

Student Housing Address:

Please complete the following contact sheet.

Once a student's application has been received we will contact the following individuals to set up the rotation and all specifics related to the rotation.

1. **Administrative Contact**: Individual to contact regarding participation and payment of student stipend.

_____ _____

First Name ***Last Name*** ***Title***

Phone: _____ ***Email:*** _____

2. **Credentialing Contact**: Individual to contact to verify and submit student credentialing information.

_____ _____

First Name ***Last Name*** ***Title***

Phone: _____ ***Email:*** _____

3. Housing Contact: Individual to contact to schedule student housing.

_____ _____

First Name ***Last Name*** ***Title***

Phone: _____ ***Email:*** _____

4. Preceptor Scheduling Contact: Individual to contact to schedule the rotation with the physician preceptor(s).

_____ _____

First Name ***Last Name*** ***Title***

Phone: _____ ***Email:*** _____

5. Please indicate who the student should contact prior to their arrival to schedule mandatory orientations and/or training, and who to contact in regards to accessing the provided housing if applicable (If not listed above please provide contact information).

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