Virginia AHEC Scholars

Community/Clinical Activity Hours Tracking Form

Please submit all Community/Clinical Activity Hours via this tracking form by August 31 of your current scholar year.
If you have any questions or are unable to submit by the due date, please contact your coordinator.

Scholar Information:

Last Name:	First Name:	Mi:	Phone Number:

Address:	Zip Code:	Preferred Email:

Race/Ethnicity:
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic or Latino ☐ Hawaiian or Other Pacific Islander ☐ White/Caucasian
☐ Mixed/Biracial _____ ☐ Other _____

Gender Identity:
☐ Male ☐ Female ☐ Non-Binary
☐ Other _____

Activity & Preceptor Information:

Preceptor Site:	Telephone #:	Site Location: ☐ MUA/P ☐ Rural ☐ Not Reported

Site Address of Activity:	City:	State:	Zip Code:

Start Date (MM/DD/YYYY):	End Date (MM/DD/YYYY):	Preceptor Name(s):

Population Group: (select all that apply)
☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Hispanic or Latino
☐ Hawaiian or Other Pacific Islander ☐ White/Caucasian
☐ Not Reported

Core Topics Included (Activity MUST include at least one(1) core topic. Select all that apply):
☐ Cultural Competency ☐ Opioid Use Disorders
☐ Social Determinants of Health ☐ Practice Transformation
☐ Inter-professional Practice ☐ Behavioral Health Integration

Activity	Preceptor Signature	# of Hours

Activity Comments:

See second page to submit additional Activities.

FORM MUST BE SIGNED BY BOTH SCHOLAR AND PRECEPTOR, OTHERWISE ACTIVITY HOURS WILL NOT BE TRACKED.

AHEC Scholar (Student)

By signing below, I pledge that this information is true. If not, any hours tracked on this form will not count towards my program requirements and I may be removed from the program. I also acknowledge that I must notify my Center Director (or designee) as soon as possible if any changes occur in rotation institution, schedule, or supervising faculty listed on this form; if I am involved in a patient safety issue at my rotation site; or if there is insufficient supervision or unsafe working conditions at my training site.

Signature **Date**

Submit additional Activities here.

Activity & Preceptor Information:			
Preceptor Site:	**Telephone #:**		**Site Location:** ☐ MUA/P ☐ Rural ☐ Not Reported
Site Address of Activity:	**City:**	**State:**	**Zip Code:**
Start Date (MM/DD/YYYY):	**End Date** (MM/DD/YYYY):	**Preceptor Name(s):**	

Population Group: (select all that apply)

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- ☐ White/Caucasian
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- ☐ Inter-professional Practice
- ☐ Behavioral Health Integration

Activity	Preceptor Signature	# of Hours

Activity Comments:

Activity & Preceptor Information:			
Preceptor Site:	**Telephone #:**		**Site Location:** ☐ MUA/P ☐ Rural ☐ Not Reported
Site Address of Activity:	**City:**	**State:**	**Zip Code:**
Start Date (MM/DD/YYYY):	**End Date** (MM/DD/YYYY):	**Preceptor Name(s):**	

Population Group: (select all that apply)

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Activity	Preceptor Signature	# of Hours

Activity Comments: