South Carolina AHEC Program Office
Medical University of South Carolina
1 South Park Circle
Suite 203
Charleston, SC 29407

Rural Physician Program Application

INSTRUCTIONS: Complete this application to receive consideration for the South Carolina AHEC State Incentive Grant. **Please attach Curriculum Vitae and Practice Site Profile (Required).** *An email will be sent to each applicant confirming the application packet is complete. If an email isn't received within three business days, please email the South Carolina AHEC office at cochrak@musc.edu to confirm receipt. No late applications will be accepted.*

Application Part 1

I. Personal Information

1. Name _____ (Last) _____ (First) _____ (MI)
2. Current Home Address _____ (Address)
   _____ (City) _____ (State) _____ (Zip)
3. Home Telephone _____ (With Area Code)
4. Current Work Address _____ (Business Name)
   _____ (Address)
   _____ (City) _____ (State) _____ (Zip)
5. Work Telephone _____ (With Area Code)
6. Email Address _____
7. Are you a U.S. citizen? (Yes/No) _____
8. Are you a SC resident? (Yes/No) _____
9. Are you Hispanic/Latino? (Yes/No) _____
10. Race (Please check all that apply)
    - American Indian/Alaska Native ☐
    - Asian ☐
    - Black ☐
    - Native Hawaiian or Other Pacific Islander ☐
    - White ☐
11. Total Educational Indebtedness $_____
12. Have you previously applied for funding through the South Carolina Rural Physician Program (Incentive

Grant or Loan Repayment)? (Yes/No) _____ Were you funded? (Yes/No) _____

www.scahec.net
(843) 792-4431 / (843) 792-4430 Fax

II. Professional Background

1. Medical School/Health Professions Program _____

   Date of Graduation (Month/Year) _____

   Is the health professions program an online program? (Yes/No) _____
   If yes, please indicate the state where the majority of clinical training was completed. _____

   Were you a South Carolina AHEC Institute for Primary Care Education and Practice fellow during your health professions training? (Yes/No) _____

2. Clinical Specialty
   - Family Practice ☐
   - Internal Medicine ☐
   - Internal Medicine/Pediatrics ☐
   - Ob/Gyn ☐
   - Pediatrics ☐
   - General Surgery ☐
   - Psychiatry ☐
   - Other ☐ If other, please list. _____

3. Practitioner Type
   - Nurse Midwife ☐
   - Nurse Practitioner ☐
   - Physician ☐
   - Physician Assistant ☐

4. Current Training Status
   - Advanced Practice Student ☐
   - Resident ☐
   - Fellow ☐
   - Training Complete ☐

5. Most Recent Residency Program/Fellowship Completed _____
   Name of Residency Program/Fellowship
   _____ _____ _____ _____
   Primary Street Address of Program | City | State | Zip

6. Date you will complete/completed residency program (Month/Year) _____

7. Have you completed a Rural Residency Training Track? (Yes/No) _____

8. Additional Residency/Fellowship Training _____
   Name of Residency Program/Fellowship
   _____ _____ _____ _____
   Primary Street Address of Program | City | State | Zip

9. Date you completed additional residency/fellowship training (Month/Year) _____

10. Are you Board/Professionally Certified? (Yes/No) _____
    What Clinical Area(s)? _____ Date of Certification _____

Month/Year

11. If you are not Board Certified, do you expect to receive board certification within a year? (Yes/No) _____

12. South Carolina Licensing Agency_____ South Carolina License Number_____

III. Other Sources of Funding

1. Did you incur a service obligation with any state, government, or other entity while obtaining your medical/health professions degree? (Yes/No) _____

If yes, please describe the type of obligation, including the starting and ending dates.

_____

_____

2. Have you received or will you be receiving any other loan repayment or practice incentives from state, federal or private sources? Note: The National Health Service Corps (NHSC) doesn't allow recipients to receive funding from both the NHSC and the Rural Physician Program at the same time. (Yes/No) _____

If yes, please provide the source, amount and duration of these funds.

_____

_____

_____

IV. Incentive Grant Practice Location(s)

Please indicate your intended practice location(s) for purposes of incentive grant funding.

Primary Practice Location Information

1. Primary Practice Location

_____

Name of Practice

_____ _____ _____ _____

Street Address of Practice City State Zip

2. Practice County_____

3. Practice Type (Please check one) Community Health Center ☐

Federally Qualified Health Center ☐

Group Practice ☐

Rural Health Center ☐

Solo Practice ☐

Other ☐ If other, please list. _____

4. How many hours per week do you expect to serve at this location? _____

5. How long have you been in clinical practice at the above location? _____

6. If not yet in practice at the above location, when will you begin clinical practice at this location? _____

Secondary Practice Location Information (If Applicable)

7. Secondary Practice Location

_____
Name of Practice

_____ _____ _____ _____
Street Address of Practice City State Zip

8. Practice County_____

9. Practice Type (Please check one) Community Health Center ☐

Federally Qualified Health Center ☐

Group Practice ☐

Rural Health Clinic ☐

Solo Practice ☐

Other ☐ If other, please list: _____

10. How many hours per week do you expect to serve at this location? _____

11. How long have you been in clinical practice at the above location? _____

12. If not yet in practice at the above location, when will you begin clinical practice at this location? _____

V. Applicant Background Information

1. Date of Birth _____

2. Place of Birth _____ _____
City State

3. Did you live in a rural area/small town between the ages of 12-18? (Yes/No) _____

If yes, please provide the city and state.

_____ _____
City State

4. Home Prior to College _____ _____
City State

5. High School at Time of Graduation _____
Name

_____ _____
City State

6. College or University at Time of Graduation _____
Name

_____ _____
City State

7. Spouse/Partner's Place of Birth _____ _____
City State

8. Did your spouse/partner live in a rural area/small town between the ages of 12-18? (Yes/No) _____

If yes, please provide the city and state.

_____ _____
City State

9. Spouse/Partner's Home Prior to College _____ _____

City State

10. Spouse/Partner's College or University at Time of Graduation _____
Name

_____ _____
City State

11. Do you or your spouse/partner have relatives currently practicing primary care medicine in rural South Carolina? (Yes/No) _____

If yes, please provide the county/counties?
_____

12. What, if any, personal connection do you have to the community where you will be practicing?
_____
_____
_____

13. Are you fluent in a language other than English? If so, please list. _____

14. Have you ever served as a preceptor for health professions students? (Yes/No) _____

If yes, please provide the disciplines. _____

I understand that application to this program indicates a desire to commit to practice in an underserved area of South Carolina for a period of time contingent upon amount of support I receive.

_____
Name Date

Please describe any professional experiences during your health professions training program, medical school or residency training that were associated with rural areas or underserved populations (include any experiences sponsored by a state AHEC program). Please note the location, population served and the length of each activity.

Please submit the completed application, curriculum vitae, and practice site profile to Kristin Cochran at cochrak@musc.edu or fax to 843-792-4430.