# TRAVEL STIPEND REQUEST

Date _____

Would you consider working in a rural or medically underserved area? Yes ___ No _____

Name: _____ Phone: _____

Mail Check to (address): _____

City: _____ State: _____ Zip: _____

School Enrolled: _____

Degree Progam Name: _____

PRACTICUM RECORD

Dates at this Site: _____

Preceptor's Name: _____

Name of Site: _____

Site's Address: _____

Amount of Stipend: $50.00

Student's Signature: _____

RETURN REQUEST TO:


SOWEGA-AHEC (229) 439-7185
1512 W Third Avenue (229) 888-5154 fax
Albany, GA 31707 roliver@sowega-ahec.org


*Thank you for helping us increase health professionals in southwest Georgia.*

OFFICE USE ONLY

Date practicum record updated: _____

Staff Initials: _____