ARKANSAS DIVISION OF HIGHER EDUCATION (ADHE)

101 East Capitol Avenue, Ste. 300 Little Rock, AR 72201

ARKANSAS HEALTH EDUCATION GRANT (ARHEG) PROGRAM

Graduate Reporting Form

NOTE: This form is to be completed by grant recipients who graduated from professional studies with the assistance of the Arkansas Health Education Grant (ARHEG) Program. The form is to be submitted every year in September for four (4) years following graduation, including your graduation year. Feel free to make copies as needed. **ALL INFORMATION IS REQUIRED!**

NAME (include name change if any) **SSN**

OCCUPATION/TITLE (DDS, OD, etc) **GRADUATION YEAR**

NAME OF ARHEG INSTITUTION **FIELD OF STUDY**

CURRENT MAILING ADDRESS **CITY** **STATE** **ZIPCODE**

PHONE (INCLUDING AREA CODE) **EMAIL ADDRESS**

CURRENT EMPLOYER OR SCHOOL (RESIDENCY PROGRAM)

EMPLOYER'S OR SCHOOL ADDRESS **CITY** **STATE** **ZIP**

EMPLOYER'S OR SCHOOL PHONE (INCLUDING AREA CODE) **EMAIL**

ARE YOU LICENSED TO PRACTICE IN ARKANSAS? YES_____ NO ______

LICENSE NO. **YEAR RECEIVED** **INITIAL DATE OF PRACTICE?**

ARE YOU LICENSED TO PRACTICE IN ANY OTHER STATE? YES_____ NO ______

IF YES, PLEASE PROVIDE THE STATE/S ______________________________________

LICENSE NO. **YEAR RECEIVED**

Mail to address in letterhead.

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