ARKANSAS DEPARTMENT OF HIGHER EDUCATION (ADHE)

423 Main Street, Suite 400, 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**

FAX COMPLETED FORM TO: ARHEG Coordinator 501-371-2001 OR mail to address in letterhead.