

Health Careers Program
INFORMATION UPDATE FORM
To Be Completed by HCP Graduates

OFFICE USE ONLY	
Graduated?	<input type="checkbox"/>
Active?	<input type="checkbox"/>

Your 8 digit Participant Identification number is made up of: 2 digits of your birth month (01-12), 2 digits of your birth day (01-31), and the last four digits of your Social Security Number. This identifier protects your personal information in our database and allows us to provide you credit for this course.

Example: the Participant ID for someone born 11/21/1989 with the SSN 123-45-6666 would be: 11/21/6666

Participant ID ___ ___ / ___ ___ / ___ ___ ___ ___

Name: _____ Date: _____

Maiden Name: _____ Email: _____

Permanent Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Please complete this section only if you are still attending school.

School Name _____

Degree/Credential Program: _____ Anticipated Graduation Date: _____

Grade Level: (Circle one) Freshman, Sophomore, Junior, Senior, Post Graduate

GPA: _____ Major/Course of Study: _____

Please complete this section only if you are a Practicing Health Professional.

Degree/Credentials: _____ Job Title: _____

Current Employer's Name: _____

Current Employer's Address: _____

City: _____ State: _____ Zip: _____

County: _____ Office Phone: _____

Comments: _____

My Comments May Be Used By South Carolina AHEC For Promotional Purposes [] Yes [] No

Signature: _____