



Student Externship Matching Grant Program REQUEST FOR PAYMENT

- **SUBMIT THIS FORM AS SOON AS STUDENT AND MENTOR HAVE BEEN MATCHED**
- Complete a Request for Payment form *for each student* funded by a matching grant program (if multiple students are funded complete multiple forms).
- Send this form by email to vroberts@aafp.org.
- Deadline to submit all Request for Payment forms is August 1
- Questions or need more information? Call 1-800-274-2237, ext. 6239 or email vroberts@aafp.org.

*Please type your name, title, and date below indicating your **commitment to adhere to the stated principles and procedures, as set forth in the Student Externship Matching Grant Notice of Award with Guidelines.***

Name: Title: Date:

CHAPTER/CHAPTER FOUNDATION (Name as it should appear on payment):

Number of students funded by this matching grant:

Are you funding any externships NOT matched by this grant program?

Dates the externship will take place: Beginning: Ending:

Please note that the AAFP Foundation will send a survey to the student directly following the completion of the externship and we will copy you on the results of the survey.

PLEASE ASK EACH EXTERN FUNDED BY A MATCHING GRANT THIS QUESTION PRIOR TO BEGINNING THE EXTERNSHIP: On a scale of 0 to 10, what is your *current* interest in Family Medicine:

Number of weeks of the externship:

Full name of extern:

Date of birth:

Year completed in medical school: M1 M2 M3 M4

Address of student:

School E-mail address of student:

Personal E-mail address of student:

Name of medical school:

Name of mentoring family physician:

Clinical, Research, or Mixed Externship (if research, specify topic):

Rural, Suburban, Urban or Mixed Externship:

Practice setting (please describe, e.g. solo practice, multi-specialty clinic, FQHC, FMRP, etc):

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Submit this form to vroberts@aafp.org as soon as student & mentor are matched.