

## National Laboratory Training Network Registration Form

(Please type or print.)

**Training Event Title:** \_\_\_\_\_

**Event Code:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Location:** (City, State) **or Event Type:** (e.g., teleconference)

**Applicant's Information**

**Title:** (Dr./Mr./Miss/Ms./Mrs.) **First Name:** \_\_\_\_\_ **M.I.** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Position Title:** \_\_\_\_\_ **State Licensure Number** (if applicable): \_\_\_\_\_

**Employer's Name:** \_\_\_\_\_

**Mailing Address:** (Please specify, Employer's or your Home address?) \_\_\_\_\_

**City:** \_\_\_\_\_ **State/Country:** \_\_\_\_\_ **Zip/Postal Code:** \_\_\_\_\_  
**Work Telephone Number:** \_\_\_\_\_ **Work Fax Number:** \_\_\_\_\_

**E-mail Address:** (Applicant must provide an e-mail address to receive an NLTN confirmation of registration.) \_\_\_\_\_

(To receive *future* training event notifications, please circle, **YES**.)

(Please review all options in the three categories before circling the one most appropriate in each category.)

**Occupation**

- Physician 01
- Veterinarian 02
- Laboratorian 04
- Nursing Professional 05
- Sanitarian 06
- Administrator 08
- Safety Professional 11
- Educator 13
- Epidemiologist 14
- Environmental Scientist 15
- Other \_\_\_\_\_ 12

**Type of Employer**

- Public Health Department (State or Territorial) 01
- Public Health Department (Local, City or County) 03
- Government (Other Local, not City or County) 04
- Centers for Disease Control and Prevention 05
- U.S. Food and Drug Administration 09
- U.S. Department of Defense 11
- Veterans Administration Medical Center/Hospital 12
- Other (Federal Employer) \_\_\_\_\_ 15
- Foreign 16
- College or University 19
- Private Industry 21
- Private Clinical Laboratory 23
- Physician's Office Laboratory/Group Practice 24
- Hospital 33
- Health Maintenance Organization 28
- Non-profit 31
- Unemployed or Retired 32
- Environmental Laboratory 34
- Veterinary Laboratory 35
- Agricultural Laboratory 36
- Other \_\_\_\_\_ 30

**Education Level** (Highest Completed)

- Degree
- Associate 04
- Bachelor 05
- Masters 06
- Doctoral (M.D.) 07
- Doctoral (Other than M.D.) 08
- Technical/Hospital School 09
- Some College 03
- High School Graduate 02
- Some High School 01
- Other \_\_\_\_\_ 10

**Return form to**

The information requested on this form is collected under the authority of 42 U.S.C., Section 243 (CDC). The requested information is used only to process your training registration and will be disclosed only upon your written request.

Continuing education credit can only be provided when all requested information is submitted. Furnishing the information requested on this form is voluntary.

Public reporting burden for this collection of information is estimated to average five minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

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Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, N.E., Mail Stop D24, Atlanta, GA 30333 ATTN: PRA (0920-0017).