

Event code \_\_\_\_\_

Form Approved  
OMB No.: 0930-0216  
Exp. Date XX/XX/XXXX  
See burden statement on back of page

### Attachment 1-3: ATTC Pre-Event Form—Training

Personal Code:

\_\_\_ First Letter in Mother's First Name  
\_\_\_ First digit in Social Security Number

\_\_\_ First Letter in Mother's Maiden Name  
\_\_\_ Last digit in Social Security Number

Birth Year: 19\_\_\_\_

Previous ATTC Participant: \_\_\_ Yes \_\_\_ No

Gender: \_\_\_ Male \_\_\_ Female

Are you Hispanic or Latino? \_\_\_ Yes \_\_\_ No

Race (Check all that apply):

\_\_\_ Black or African American \_\_\_ Asian \_\_\_ American Indian  
\_\_\_ Native Hawaiian/Other Pacific Islander \_\_\_ Alaska Native \_\_\_ White

Years of Experience in Addictions:

\_\_\_ I have worked in the addiction field for \_\_\_\_\_ years.  
\_\_\_ I am not employed in the addiction field.

Certification Status in Addictions Field:

\_\_\_ Not certified or licensed in addictions \_\_\_ Currently certified or licensed  
\_\_\_ Previously certified or licensed, not now \_\_\_ Intern

Highest Degree Status:

\_\_\_ No high school diploma or equivalent \_\_\_ Bachelor's degree  
\_\_\_ High school diploma or equivalent \_\_\_ Master's degree  
\_\_\_ Some college, but no degree \_\_\_ Doctoral degree or equivalent  
\_\_\_ Associate's degree \_\_\_ Other, specify: \_\_\_\_\_

Discipline/Profession (Please check all that apply)

\_\_\_ Addictions Counselor \_\_\_ Social Work/Human Services \_\_\_ Administration  
\_\_\_ Other Counseling \_\_\_ Physician Assistant \_\_\_ None, unemployed  
\_\_\_ Education \_\_\_ Medicine – Primary Care \_\_\_ None, student  
\_\_\_ Vocational Rehabilitation \_\_\_ Medicine – Psychiatry \_\_\_ Other, specify: \_\_\_\_\_  
\_\_\_ Criminal Justice \_\_\_ Medicine – Other \_\_\_\_\_  
\_\_\_ Psychology \_\_\_ Nurse/Nurse Practitioner \_\_\_\_\_

Primary Work Setting (please check all that apply):

\_\_\_ Criminal Justice \_\_\_ Private practice \_\_\_ Student  
\_\_\_ Outpatient \_\_\_ Outreach \_\_\_ Other, specify: \_\_\_\_\_  
\_\_\_ Inpatient facility \_\_\_ Substance Abuse Treatment agency \_\_\_\_\_  
\_\_\_ Educational institution \_\_\_ Community Mental Health center \_\_\_\_\_  
\_\_\_ Residential facility \_\_\_ Health/community health agency \_\_\_\_\_

Primary Job Responsibility: (please check all that apply)

\_\_\_ Line staff (counselors, K-12 teachers, corrections officers, etc.) \_\_\_ Administration  
\_\_\_ Supervision of case managers and/or counselors \_\_\_ Training/Education  
\_\_\_ Other (specify: \_\_\_\_\_)

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**Current Training Goals: (check all that apply)**

- \_\_\_\_\_ Professional development (no CEUs)
- \_\_\_\_\_ Addictions certification (state or other)
- \_\_\_\_\_ Academic credit toward a Master's
- \_\_\_\_\_ Other (specify): \_\_\_\_\_

- \_\_\_\_\_ Continuing education (CEUs awarded)
- \_\_\_\_\_ Academic credit toward a BA
- \_\_\_\_\_ Academic credit toward licensure
- \_\_\_\_\_ No current goals

PLEASE INDICATE YOUR AGREEMENT WITH THESE STATEMENTS ABOUT THE TRAINING.

	<b><u>Strongly Agree</u></b>	<b><u>Agree</u></b>	<b><u>Neutral</u></b>	<b><u>Disagree</u></b>	<b><u>Strongly Disagree</u></b>
1. I am currently effective when working in this topic area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I expect to use the information gained from this training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I have adequate knowledge in this topic area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I possess the skills required in this topic area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Public reporting burden for this collection of information is estimated to average 8 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. Send comments regarding this burden estimate or any other aspect of this collection of information to the SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0216.