

PIF

HRSA AIDS Education and Training Centers  
PARTICIPANT INFORMATION FORM

**Please completely fill in the circles (●) when answering the questions below.**

1. To create your unique ID number, use the month of your birth, day of your birth, and last four digits of your SSN. For example, May 29, 123-345-6789, has the ID number 05296789.

M	M	D	D	#	#	#	#

*Birth* *Last 4 SSN*

**Unique ID Number**

2. Today's Date (mm/dd/yy)

		/			/		
<i>mm</i>	<i>dd</i>		<i>dd</i>	<i>yy</i>		<i>yy</i>	

3. Your Primary Profession/Discipline (Select one)

- Dentist
- Other Dental Professional
- Nurse Practitioner
- Other Advanced Practice Nurse
- Nurse
- Pharmacist
- Physician
- Physician Assistant
- Clergy/Faith-Based Professional
- Dietitian/Nutritionist
- Health Educator
- Mental Health Professional
- Public Health Professional
- Social Worker
- Substance Abuse Professional
- Other (specify): \_\_\_\_\_

4. Your Primary Functional Role (Select one)

- Administrator
- Agency Board Member
- Care Provider/Clinician
- Case Manager
- Client/Patient Educator
- Intern/Resident
- Researcher/Evaluator
- Student/Graduate Student
- Teacher/Faculty
- Other (specify): \_\_\_\_\_

5. Your Principal Employment Setting (Select one)

- Clinic
- Academic Health Center
- Community Health Center
- Family Planning
- HIV Clinic
- Hospital-Based Clinic
- Indian Health Services/Tribal
- Infectious Disease
- Maternal/Child Health
- Mental Health
- Rural Health
- Sexually Transmitted Disease
- Substance Abuse
- Other Settings
- College/University
- Community-Based Organization
- Correctional Facility
- HMO/Managed Care Organization
- Hospital/ ER
- Military/VA
- Private Practice
- State/Local Health Department
- Non-Health
- Other Primary Care
- Not Working (skip to item 9)

6. Primary Employment Setting/Zip code

- a.  Rural  Suburban  Urban

b. 

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*Zip code*

7. Is the employment setting a faith-based organization?  
 Yes  No  Don't Know

8. Does the employment setting receive Ryan White CARE Act funding?  
 Yes  No  Don't Know  
If you don't know, please write the full name of your employer:  
\_\_\_\_\_

9. Are you of Hispanic, Latino/a, or Spanish origin?  
 Yes  No

10. Your Racial Background (Select all that apply):

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

11. Your Gender:

- Female  Male  Transgender

12. Do you provide services directly to clients/patients?  
 Yes  No [Stop here. You are done with this form.]

13. Do you provide services directly to HIV-infected clients/patients?  
 Yes  No/Don't Know [Stop here. You are done with this form.]

14. How many years have you been providing services directly to HIV-infected clients/patients? [Round up to the nearest whole year.]

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15. Estimate the NUMBER of HIV-infected clients/patients to whom you provide direct services in an average MONTH.

- None [Stop here. You are done with this form.]  
 1-9  10-19  20-49  50+

For questions 16-18, estimate the PERCENTAGE of your HIV-infected clients/patients in the past YEAR who were:

16. Racial or Ethnic Minorities

- None  1-24%  25-49%  50-74%  ≥75%

17. On Antiretroviral Therapy

- None  1-24%  25-49%  50-74%  ≥75%

18. Women

- None  1-24%  25-49%  50-74%  ≥75%

For Office Use Only	February 2007	<table border="1"><tr><td></td><td></td></tr></table> AETC			<table border="1"><tr><td></td><td></td><td></td></tr></table> Sub-site				<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> Program ID									<table border="1"><tr><td></td><td></td><td></td></tr></table> Agency				Ryan White CARE Act <input type="radio"/> Yes <input type="radio"/> No