

## PARTICIPANT INFORMATION FORM – *Please print clearly*

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Today's date \_\_\_\_\_  
Course title \_\_\_\_\_ Course date \_\_\_\_\_

First name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last name \_\_\_\_\_  
Degree \_\_\_\_\_ Title/Position \_\_\_\_\_  
Organization \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country (if not US) \_\_\_\_\_  
Daytime Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Your Unique ID number is the first two letters of your first name, the first two letters of your last name, the month of your birth, and the day of your birth. *For example:* John Smith, May 29 would be **JOSM0529**.

FN	FN	LN	LN	M	M	D	D		

UNIQUE IDENTIFIER

**1. Your primary profession/discipline (select ONE)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Dentist<br><input type="checkbox"/> Other dental professional<br><input type="checkbox"/> Advanced practice nurse<br><input type="checkbox"/> Registered nurse<br><input type="checkbox"/> Licensed practical nurse<br><input type="checkbox"/> Pharmacist<br><input type="checkbox"/> Physician<br><input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Clergy/Faith-Based Professional<br><input type="checkbox"/> Dietitian/Nutritionist<br><input type="checkbox"/> Health Educator<br><input type="checkbox"/> Mental/behavioral health professional<br><input type="checkbox"/> Social worker | <input type="checkbox"/> Substance abuse professional<br><input type="checkbox"/> Community health worker<br><input type="checkbox"/> Other<br><i>(please specify)</i> _____ |
|---|---|--|

**2. Your primary functional role (select ONE)**

- |  |   |
|--|---|
| <input type="checkbox"/> Administrator (director, coordinator, manager, supervisor)<br><input type="checkbox"/> Agency Board member<br><input type="checkbox"/> Clinician/Care provider<br><input type="checkbox"/> Case manager<br><input type="checkbox"/> Client/patient counselor<br><input type="checkbox"/> Client/patient educator<br><input type="checkbox"/> Clinical/medical assistant<br><input type="checkbox"/> Disease intervention specialist / Partner services provider | <input type="checkbox"/> Intern /resident<br><input type="checkbox"/> Mental/behavioral health therapist<br><input type="checkbox"/> Outreach staff<br><input type="checkbox"/> Peer support provider<br><input type="checkbox"/> Researcher / evaluator<br><input type="checkbox"/> Student/Graduate Student<br><input type="checkbox"/> Teacher / faculty<br><input type="checkbox"/> Trainer / TA Provider<br><input type="checkbox"/> Other <i>(please specify)</i> _____ |
|--|---|

**3. Your principal employment setting (select ONE):**

- |   |   |
|---|---|
| <input type="checkbox"/> Academic Health Center   | <input type="checkbox"/> Hospital/Hospital-affiliated clinic                    |
| <input type="checkbox"/> College/University   | <input type="checkbox"/> Military Health System/ Veterans Health Admin facility |
| <input type="checkbox"/> Community-based service organization (CBO)                       | <input type="checkbox"/> Private practice (Solo/group)                          |
| <input type="checkbox"/> Community health center (e.g. Federally Qualified Health Center) | <input type="checkbox"/> Rural health center                                    |
| <input type="checkbox"/> Other non-profit health center                                   | <input type="checkbox"/> State/local health department                          |
| <input type="checkbox"/> Community/retail pharmacy  | <input type="checkbox"/> Tribal/Indian Health Service facility                  |
| <input type="checkbox"/> Correctional facility  | <input type="checkbox"/> Non-Health Setting                                     |
| <input type="checkbox"/> HMO/managed care organization                                    | <input type="checkbox"/> Other: (please specify)                                |
|   | <input type="checkbox"/> Not working_(Go to question 11)_____                   |

**4. Primary programmatic focus of your work (select up to TWO):**

- |  |  |
|--|--|
| <input type="checkbox"/> HIV/AIDS                                    | <input type="checkbox"/> Adolescent and/or pediatric health          |
| <input type="checkbox"/> STD   | <input type="checkbox"/> Emergency medicine / urgent care            |
| <input type="checkbox"/> TB  | <input type="checkbox"/> Primary care (e.g. general/family medicine) |
| <input type="checkbox"/> Hepatitis                                   | <input type="checkbox"/> Mental/behavioral health                    |
| <input type="checkbox"/> Reproductive health / family planning       | <input type="checkbox"/> Oral health                                 |
| <input type="checkbox"/> Recovery support/ trauma/ domestic violence | <input type="checkbox"/> Other infectious diseases                   |
| <input type="checkbox"/> Labor and delivery                          | <input type="checkbox"/> Other (please specify)_____                 |

**5. Primary Employment Setting**

- a.  Rural       Suburban/urban

b. Zip code

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**6. Is your employment setting a faith-based organization?**

- Yes       No       Don't Know

**7. Does your employment setting receive funding from any of these sources (select all that apply)?**

- |                              |                              |                             |                                     |
|------------------------------|------------------------------|-----------------------------|-------------------------------------|
| a. Ryan White Program        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| b. Title X / Family Planning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| c. CDC                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| d. SAMHSA                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| e. Minority AIDS Initiative  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

**8. Please write the FULL name of your agency:**

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Some programs and organizations provide services to a particular population group. In the following questions, please tell us about the population groups your program or organization serves.

9. Does your program predominantly serve any **racial and ethnic minority** groups?

- Yes (answer question 9a)
- No, my program does not focus on any specific racial and ethnic groups (Go to question 10)
- Don't know (Go to question 10)

9a. If yes, select up to TWO of the following **racial and ethnic** groups that are a focus of your program:

- American Indians or Alaska Natives
- Asians
- Blacks or African Americans
- Hispanics or Latinos/as
- Native Hawaiians or Pacific Islanders

10. Does your program predominantly serve any **special populations**?

- Yes (answer question 10a)
- No, my program does not focus on any specific population groups (Go to question 11)
- Don't know (Go to question 11)

10a. If yes, choose up to THREE of the following populations served by your program:

- Adolescents
- HIV+ individuals
- Homeless individuals
- Incarcerated individuals/parolees
- Low-income individuals
- Men who have sex with men
- Men who have sex with men and women
- Older adults
- Pregnant women
- Recent immigrants/refugees/migrants or seasonal workers
- Sex workers
- Substance users
- Transgender individuals
- Women
- Other (please specify) \_\_\_\_\_

11. Are you of **Hispanic, Latino/a, or Spanish** origin?

- Yes
- No

12. What is your racial background? (Select all that apply?)

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

13. What is your gender?

- Female
- Male
- Transgender: Female to male
- Transgender: Male to female

14. Do you provide services directly to clients or patients?

- Yes (Go to question 15)
- No (Stop here. You are done with this form.)

15a. Please estimate the **PERCENTAGE** of your **OVERALL CLIENT/PATIENT** population in the past **YEAR** who were racial-ethnic minorities:

- None/yr.
- 1-24%/yr.
- 25-49%/yr.
- 50-74%/yr.
- ≥75%/yr.

**15b. Please estimate the PERCENTAGE of your OVERALL CLIENT/PATIENT population in the past YEAR who received routine HIV testing:**

None/yr.      1-24%/yr.      25-49%/yr.      50-74%/yr.       $\geq$ 75%/yr.  
                                                                               

**16. Do you provide services directly to HIV-infected clients/patients?**

- Yes    (Go to question 17)  
 No      (Stop here. You are done with this form.)

**17. How many YEARS have you been providing services directly to HIV-infected clients/patients?**

(Round up to the nearest whole year)

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

None/mo.    1-9/mo.      10-19/mo.    20-49/mo.    50+/mo.  
                                                                               

**For Questions 19 through 22, estimate the PERCENTAGE of your HIV-infected clients/patients in the past YEAR who are:**

**19. Racial-ethnic minorities**

None/yr.      1-24%/yr.      25-49%/yr.      50-74%/yr.       $\geq$ 75%/yr.  
                                                                               

**20. Co-infected with Hepatitis C**

None/yr.      1-24%/yr.      25-49%/yr.      50-74%/yr.       $\geq$ 75%/yr.  
                                                                               

**21. Receiving antiretroviral therapy**

None/yr.      1-24%/yr.      25-49%/yr.      50-74%/yr.       $\geq$ 75%/yr.  
                                                                               

**22. Women**

None/yr.      1-24%/yr.      25-49%/yr.      50-74%/yr.       $\geq$ 75%/yr.  
                                                                               

*Thank you for your valuable time.*