

**Think Cultural Health  
User Registration Form**

- Email Address:
- Username:
- Password:
- Confirm Password:
- First name:
- Middle initial:
- Last Name:
  
- Degree:
  - --- Select One ---
- Certificate Type:
  - --- Select One ---
  
- Address One:
- Address Two:
- City:
- State/Province:
  - --Please select--
- Zip code:
- Country:
  - --Please select--
- Gender:
  - --Please select--
- Age:
  - Less than 25
  - 25 to less than 35
  - 35 to less than 45
  - 45 to less than 55
  - 55 or over
  
- Ethnicity: (Select as many as apply)
  - Not of Hispanic, Latino, or Spanish origin
  - Mexican, Mexican Am., Chicano
  - Puerto Rican
  - Cuban
  - Another Hispanic, Latino, or Spanish origin
  - Others (may specify in write-in field: \_\_\_\_\_)
  
- Race: (Select as many as apply)
  - White
  - Black, African American
  - American Indian or Alaska Native (enter name of enrolled or principal tribe: \_\_\_\_\_)
  - Asian Indian
  - Chinese

- Filipino
  - Japanese
  - Korean
  - Vietnamese
  - Other Asian (may specify in write-in field: \_\_\_\_\_)
  - Native Hawaiian
  - Guamanian or Chamorro
  - Samoan
  - Other Pacific Islander (may specify in write-in field: \_\_\_\_\_)
  - Some other race (may specify in write-in field: \_\_\_\_\_)
- What best describes your place of employment or practice setting?(Indicate up to 3)
    - Center (hospital-based)
    - Clinic – Office-Based
    - Clinic – University-Based
    - Community-Based/Faith-Based Organization
    - Community Health Center
    - Educational Institution: K-12
    - Educational Institution: Higher Education
    - Educational Institution: Professional Education
    - Field-Based - Pre-hospital care
    - For-Profit/Corporation
    - Government – CMS QIO
    - Government – City
    - Government – County
    - Government – Tribal
    - Government – State
    - Government – Federal
    - Hospital
    - Insurance Company/Provider
    - Managed Care Organization
    - Military Facility
    - Nursing Home
    - Private Practice
    - Public Health
    - Red Cross
    - Research – Clinical
    - Research – Academic
    - VOAD
- Please indicate your level of seniority in your organization:
    - Entry
    - Mid-level
    - Professional
    - Executive
- Please indicate your number of years in your profession: Less than 5
    - 5 to 10 years

- More than 10 years
- Does Not Apply
  
- What best describes your primary role or profession?
  - Administrator or Hospital Executive
  - Education - Faculty or Staff
  - Nurse Practitioner
  - Physician Assistant
  - Policymaker or Public Official
  - Public Health
  - Disaster Personnel
    - Please select specialty from the list, or if *other* please specify: \_\_\_\_\_
  - Mental Health Professional
    - Please select specialty from the list, or if *other* please specify: \_\_\_\_\_
  - Nurse
    - Please select specialty from the list, or if *other* please specify: \_\_\_\_\_
  - Oral Health Professional
    - Please select specialty from the list, or if *other* please specify: \_\_\_\_\_
  - Physician
    - Please select specialty from the list, or if *other* please specify: \_\_\_\_\_
  - Student
    - Please select specialty from the list, or if *other* please specify: \_\_\_\_\_
  - Other
    - If other, please specify