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