Form Approved

OMB No. 0920-1099

Exp. Date: 02/28/2019

**Health Professional Application for Training – *Please print clearly***

The requested information is used only to process your training registration and will be disclosed only upon your written request. Continuing education credit can only be provided when all requested information is submitted.

Today’s date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Course title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Course date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_\_\_\_\_\_ Last name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title/Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_ Country (if not US)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bus. Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt Bus. Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bus. 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)*

|  |  |  |
| --- | --- | --- |
| 🞎 Dentist  🞎 Other dental professional  🞎 Advanced practice nurse  🞎 Registered nurse  🞎 Licensed practical nurse  🞎 Pharmacist  🞎 Physician  🞎 Physician Assistant    🞎 Criminal justice/recovery  specialist  🞎 Dietitian/Nutritionist  🞎 Epidemiologist  🞎 Health education specialist | 🞎 Clergy/Faith-Based Professional  🞎 Dietitian/Nutritionist  🞎 Health Educator  🞎 Mental/behavioral health  professional  🞎 Social worker | 🞎 Substance abuse professional  🞎 Community health worker  🞎 Other  (*please specify*)\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

|  |  |
| --- | --- |
| 🞎 Administrator (director, coordinator, manager, supervisor)  🞎 Agency Board member  🞎 Clinician/Care provider  🞎 Case manager  🞎 Client/patient counselor  🞎 Client/patient educator  🞎 Clinical/medical assistant  🞎 Disease intervention specialist / Partner services provider | 🞎 Intern /resident  🞎 Mental/behavioral health therapist  🞎 Outreach staff  🞎 Peer support provider  🞎 Researcher / evaluator  🞎 Student/Graduate Student  🞎 Teacher / faculty  🞎 Trainer / TA Provider  🞎 Other (*please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

Public reporting burden of this collection of information is estimated to average 5 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. 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-1099)

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

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

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

|  |  |
| --- | --- |
| 🞎 HIV/AIDS  🞎 STD  🞎 TB  🞎 Hepatitis  🞎 Reproductive health / family planning  🞎 Recovery support/ trauma/ domestic violence  🞎 Labor and delivery | 🞎 Adolescent and/or pediatric health  🞎 Emergency medicine / urgent care  🞎 Primary care (e.g. genera/family medicine)  🞎 Mental/behavioral health  🞎 Oral health  🞎 Other infectious diseases  🞎 Other (*please specify*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**5. Primary Employment Setting**

1. 🞎 **Rural** 🞎 **Suburban/urban**
2. **Zip code**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

**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)?**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Ryan White Program | 🞎 Yes | 🞎 No | 🞎 Don’t know |
| 1. Title X / Family Planning | 🞎 Yes | 🞎 No | 🞎 Don’t know |
| 1. CDC | 🞎 Yes | 🞎 No | 🞎 Don’t know |
| 1. SAMHSA | 🞎 Yes | 🞎 No | 🞎 Don’t know |
| 1. Minority AIDS Initiative | 🞎 Yes | 🞎 No | 🞎 Don’t know |

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*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 | 🞎 Hispanics or Latinos/as |
| 🞎 Asians | 🞎 Native Hawaiians or Pacific Islanders |
| 🞎 Blacks or African Americans |  |

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

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

**2.**

**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. ≥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. ≥75%/yr.

🞎 🞎 🞎 🞎 🞎

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

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

🞎 🞎 🞎 🞎 🞎

**21. Receiving antiretroviral therapy**

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

🞎 🞎 🞎 🞎 🞎

**22. Women**

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

🞎 🞎 🞎 🞎 🞎

*Thank you for your valuable time.*

Local Use Only:

EventID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_