**Form Approved**

**OMB No. 0920-New**

**Expiration Date 00/00/000**

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**– *Please print clearly***

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

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

First name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Last name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Daytime Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

**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**

**6.**



**7.**

**8.**

*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.*















**12. What is your racial background? (Select all that apply?) Now Question 5.**

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

**11. Are you of Hispanic, Latino/a, or Spanish origin? Now Question 6**

🞎 Yes 🞎 No

**13. What is your gender**? **Now Question 7**

🞎 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.)

*Thank you for your valuable time.*