**Form Approved**

**OMB No. 0920-New**

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 **– *Please print clearly***

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

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

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

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

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

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

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

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

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**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.*

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

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| --- | --- |
|  🞎 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.*