Form Approved

OMB No. 0920-1099

Expiration Date: XX/XX/XXXX

Capacity Building Assistance Program: Assessment and Quality Control

Attachment 3

Health Professional Application for Training (HPAT)

Health Professional Application for Training – *Please print clearly*

Privacy Act Statement:

This information is collected under the authority of the Public Health Service Act, Section 301, "Research and Investigation," (42 U.S.C. 241); and Sections 304, 306 and 308(d) which discuss authority to maintain data and provide assurances of confidentiality for health research and related activities (42 U.S.C. 242 b, k, and m(d)). This information is also being collected in conjunction with the provisions of the Government Paperwork Elimination Act and the Paperwork Reduction Act (PRA). This information will only be used by the Centers for Disease Control and Prevention (CDC) staff to collect the requested information 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
- ☐ 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. Primary Employment Setting

a. ☐ Rural ☐ Suburban/urban

b. 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)?

a. Ryan White Program	☐ Yes	☐ No	☐ Don't know
b. Title X / Family Planning	☐ Yes	☐ No	☐ Don't know
c. CDC	☐ Yes	☐ No	☐ Don't know
d. SAMHSA	☐ Yes	☐ No	☐ Don't know
e. 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
☐ Asians
☐ Blacks or African Americans
☐ Hispanics or Latinos/as
☐ Native Hawaiians or Pacific Islanders

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
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ White

12. Are you of Hispanic, Latino/a, or Spanish origin?

☐ Yes ☐ No

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: _____