

TODAY'S DATE

Your confidential ID number is the first two letters of your

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NNPTC Abbreviated Health Professional Application for Training

Public reporting burden of this collection of information is estimated to average 3 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: PRA (0920-0995).

First Name _____ Middle Initial _____ Last Name _____

Degree _____ Title/Position _____

Full name of your Organization _____

Organization Address _____

City _____ State _____ Zip code _____ Country _____

Daytime Phone _____ E-mail _____

1. Your primary profession/discipline (select ONE that best describes your profession; If student, select goal)

- | | | |
|---|--|---|
| <input type="checkbox"/> Academic faculty | <input type="checkbox"/> Laboratory specialist | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Advanced practice nurse/Nurse Practitioner | <input type="checkbox"/> Mental/behavioral health professional | <input type="checkbox"/> Registered nurse |
| <input type="checkbox"/> Clinic manager/director | <input type="checkbox"/> Physician | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Social worker |
| <input type="checkbox"/> Health educator | <input type="checkbox"/> Public health worker | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Licensed practice nurse | | |

2. Your primary functional role (select ONE that best describes your primary role)

- | | | |
|--|--|---|
| <input type="checkbox"/> Administrative (director, coordinator, manager, supervisor) | <input type="checkbox"/> Dentist | <input type="checkbox"/> Program manager |
| <input type="checkbox"/> Clinician (Physician, Nurse) | <input type="checkbox"/> Faculty | <input type="checkbox"/> Resident |
| <input type="checkbox"/> Clinical Assistant | <input type="checkbox"/> Laboratory specialist | <input type="checkbox"/> Researcher/evaluator |
| <input type="checkbox"/> Case manager/Care coordinator | <input type="checkbox"/> Mental/behavioral health professional | <input type="checkbox"/> Student/Intern |
| <input type="checkbox"/> Client educator/Counselor | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Social worker |
| <input type="checkbox"/> Disease Intervention Specialist | <input type="checkbox"/> Public health specialist | <input type="checkbox"/> Outreach staff |
| | | <input type="checkbox"/> Other (please specify) _____ |

3. Primary programmatic focus of your work (select ONE that best describes your area of work or clinical specialty)

- | | | |
|--|---|---|
| <input type="checkbox"/> HIV | <input type="checkbox"/> Maternal Health | <input type="checkbox"/> Mental/behavioral health |
| <input type="checkbox"/> STD/STI | <input type="checkbox"/> Pediatric and Adolescent health | <input type="checkbox"/> Oral health |
| <input type="checkbox"/> Other Infectious disease | <input type="checkbox"/> Emergency medicine / urgent care | <input type="checkbox"/> Public health program |
| <input type="checkbox"/> Reproductive health / family planning /Women's health | <input type="checkbox"/> Primary care | <input type="checkbox"/> Disease surveillance |
| <input type="checkbox"/> Recovery support/ trauma/ domestic violence | | <input type="checkbox"/> Other (please specify) _____ |

4. **Your primary employment setting** (select ONE)

- | | | |
|--|--|--|
| <input type="checkbox"/> Academic Health Center (High school, College) | <input type="checkbox"/> Correctional facility | <input type="checkbox"/> State/local health department |
| <input type="checkbox"/> Academic Institution (College/University) | <input type="checkbox"/> Family Planning Clinic | <input type="checkbox"/> STD Clinic |
| <input type="checkbox"/> Community-based organization (CBO) | <input type="checkbox"/> HMO/managed care organization | <input type="checkbox"/> Tribal/Indian Health Service facility |
| <input type="checkbox"/> Community health center (e.g., Federally Qualified Health Center) | <input type="checkbox"/> Hospital/Hospital-affiliated clinic | <input type="checkbox"/> Non-Health Setting |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Military Health System/Veterans Health Admin facility | <input type="checkbox"/> Other: (please specify) _____ |
| | <input type="checkbox"/> Private clinic (Solo/group) | <input type="checkbox"/> Not working |
| | <input type="checkbox"/> Rural health center | |

5. **If applicable, please select up to TWO minoritized racial and ethnic populations predominantly served by your program:**

- | | |
|--|---|
| <input type="checkbox"/> Not applicable | <input type="checkbox"/> Native Hawaiian or Pacific Islander persons |
| <input type="checkbox"/> American Indian or Alaska native persons | <input type="checkbox"/> Hispanic or Latino persons |
| <input type="checkbox"/> Asian persons | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Black persons or African Americans | |

6. **If applicable, please select up to THREE of the following special population predominantly served by your program:**

- | | | |
|---|---|--|
| <input type="checkbox"/> Not applicable | <input type="checkbox"/> Men who have sex with men | <input type="checkbox"/> Sex workers |
| <input type="checkbox"/> Ages 15 to 19 | <input type="checkbox"/> Men who have sex with men and women | <input type="checkbox"/> Substance users |
| <input type="checkbox"/> Ages 20 to 24 | <input type="checkbox"/> Older adults | <input type="checkbox"/> Transgender and gender diverse persons |
| <input type="checkbox"/> Homeless individuals | <input type="checkbox"/> People with disability | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Incarcerated individuals/parolees | <input type="checkbox"/> Pregnant people | |

7. **How do you describe your ethnicity?**

- Hispanic/Latino
 Not Hispanic/Latino

8. **How do you describe your race?** (select all that apply):

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska native | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | |

9. **Please select the gender that best describes your identity:**

- | | |
|--|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> Transgender woman |
| <input type="checkbox"/> Male | <input type="checkbox"/> Non-binary |
| <input type="checkbox"/> Transgender man | <input type="checkbox"/> Prefer not to answer |

10. **Please select the sexual orientation that best describes your identity:**

- | | |
|---|--|
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Intersex |
| <input type="checkbox"/> Gay | <input type="checkbox"/> Asexual |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Heterosexual |
| <input type="checkbox"/> Transgender | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Queer | |

11. **Do you provide services directly to clients or patients?**

Yes No (*skip logic applies*)

12. Do you provide direct services to patients / clients who are ... (*select ALL that apply*):

- | | | | |
|---------------------------|-----------------------------|------------------------------|---|
| Ages 15-19 | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not now, but expect to in the future |
| Ages 20-24 | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not now, but expect to in the future |
| Pregnant People | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not now, but expect to in the future |
| Men who have sex with men | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Not now, but expect to in the future |

13. Please estimate the NUMBER of clients/patients to whom you provide STI screening, diagnosis, or treatment in an average MONTH.

- 0 patients/Month 1-9 patients/Month 10-19 patients/Month 20-49 patients/Month 50+patients/Month

14. Do you use the CDC STI Treatment Guidelines to guide the care of your clients/ patients?

- No, I am not aware of the Guidelines
 I am aware of the Guidelines but do not use them
 I use the Guidelines occasionally
 I use the Guidelines consistently
 I use another source to guide my STD care; Please specify _____

15. Are you aware of the STI Treatment Guide mobile app that can be used to access the CDC STD Treatment Guidelines?

- No, I am not aware of the app
 I am aware of the app but I do not use it
 I use the app
 I use a different app for STD clinical information