TODAY'S DATE M M D D Y Y	Your confidential 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.	FN FN LN LN M M D D **CONFIDENTIAL IDENTIFIER**

OMB No. 0920-0995

Attachments 19 & 20

Wet Mount Long-Term Evaluation Instrument

Word version and screenshot

Wet Mount Long-Term Evaluation

Public reporting burden of this collection of information is estimated to average 2 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).

A1f. **I am using what I learned in this training in my work.**

strongly disagree ① ② ③ ④ ⑤ Strongly agree 77 NA

A2f **If you have not used what you learned, please explain why not.**

[ ]

A3f **Did you make a change in your practice or worksite setting as a result of this training**?

① Yes
⓪ No
② Not applicable to my job or patients
③ I already use these practices
④ Other reason (please specify)

[ ]

A4f **If you made a change, what change did you make**?

[ ]

A5f **As a result of this training, did you share what you learned with any of the following?** (*select all that apply*)

⓪① Supervisor
⓪① Colleagues/co-workers

⓪① Policy makers
⓪① Community
⓪① Other (please specify) ______________________________

A6f **Did any of these factors MAKE IT HARDER for you to apply the STD practices recommended in the training?** *(select all that apply)*

⓪① lack of time with patients
⓪① more important patient concerns
⓪① cost/lack of reimbursement
⓪① policies where I work
⓪① resistance to change by supervisor or colleagues
⓪① lack of equipment or supplies
⓪① no opportunity to apply practices
⓪① nothing interfered
⓪① other, please specify ____

UseGuidef **Do you use the CDC STD Treatment Guidelines to guide the care of your patients/clients?**

⓪No, I am not aware of the Guidelines
①I am aware of the Guidelines but do not use them
②I use the Guidelines occasionally
③I use the Guidelines consistently
④I use another source to guide my STD care (*please specify)* ______________