OMB No. 0906-0104
Expiration Date: 11/30/2026

HRSA IEA Activity Registration

Contact Information

First Name:	
Last Name:	
E-mail:	
Telephone Number:	
Job Title:	
Organization:	
City:	
State:	

1. Which category best describes your principal employment setting? (Select one)

Institutions of higher education:

☐ College - Community
☐ College or University

Non-profit entities:

☐ Behavioral Health (Addiction or Mental Health) Services Organization - Nonprofit
☐ Community or State Coalition
☐ Community-Based Organization
☐ Health Center
☐ Health or Human Services Provider Organization – Nonprofit
☐ Hospital - Nonprofit
☐ Professional Association
☐ Rural Health Clinic - Nonprofit

Private for-profit entities:

☐ Behavioral Health (Addiction or Mental Health) Services Organization – For profit
☐ Health or Human Services Provider Organization – For profit
☐ Hospital – For profit
☐ Rural Health Clinic – For profit
☐ Small Business

Public entities:

☐ Government – City, County or Local
☐ Government – Federal
☐ Government – State or U.S. Territory
☐ Health Department – Local
☐ Health Department - State
☐ School or School District

Tribes and Tribal organizations:

☐ Native American tribal governments
☐ Native American tribal organizations

None of the above - Other ☐

2. Has your current employer ever responded to a HRSA Notice of Funding Opportunity (i.e., applied for a HRSA award)?

☐ Yes ☐ No ☐ I do not know

3. Does your organization currently receive a HRSA grant or cooperative agreement?

☐ Yes ☐ No ☐ I do not know

4. Has your organization ever received a HRSA grant or cooperative agreement?

☐ Yes ☐ No ☐ I do not know

5. Which category best describes your role?

☐ Administrator
☐ Board Member
☐ Case Manager
☐ Certified Nursing Assistant
☐ Chiropractor
☐ Clinical Nurse Specialist
☐ Community Health Worker
☐ Counselor
☐ Dental Assistant
☐ Dental Hygienist
☐ Dentist
☐ Executive or Senior Leader
☐ Elected Official
☐ Faculty
☐ Government Health Official - State
☐ Government Health Official – City, County, or Local
☐ Health Educator
☐ Health Services Psychologist
☐ Home Visitor
☐ Manager
☐ Marriage and Family Therapist
☐ Medical Assistant
☐ Nurse Anesthetists
☐ Nurse Midwife
☐ Nurse Practitioner
☐ Occupational Therapist
☐ Peer Recovery Specialist
☐ Practical Nurse
☐ Professional Counselor
☐ Psychologist
☐ Psychiatric Nurse Specialist
☐ Physical Therapist
☐ Physician
☐ Physician Assistant
☐ Registered Nurse
☐ Researcher
☐ Social Worker
☐ Student
☐ Substance Use Disorder Counselor
☐ Teacher
☐ Tribal Leader
☐ Other

OPTIONAL QUESTIONS:

6. What is your preferred language?
☐ English ☐ Spanish ☐ Other (please specify):

7. If you are a member of a Federally Recognized Tribe, to which Tribe do you belong?
Tribe:

8. Is your organization registered to apply for federal funding (i.e., have an active SAM.gov or Grants.gov account)
☐ Yes – with both Sam.gov and Grants.gov
☐ Yes – with Sam.gov only
☐ Yes – with Grants.gov only
☐ No
☐ I do not know

9. Would you like to receive e-mails about upcoming HRSA funding opportunities, events, and other information?
☐ Yes ☐ No

10. What are your primary areas of interest? Check all that apply.
☐ Behavioral Health (Mental Health or Substance Use)
☐ Health Workforce
☐ HIV/AIDS
☐ Maternal and Child Health
☐ Primary Care
☐ Rural Health
☐ Telehealth
☐ Other:

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