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HRSA AIDS Education and Training Centers
Individual Participant Record Form (IND-PAR)

Instructions: This form should be completed or updated at least once every calendar year by participants.

1. **Unique ID number. (Enter an email address as a personal identifier.)**
   _____

2. **If applicable, please provide your individual National Provider Identifier (NPI).**

3. **Today's date:**

M	M	D	D	Y	Y	Y	Y

4. **Your primary profession/discipline/training program. Select one.**
   - Administrative professional (e.g., front desk staff, grant writer, etc.), **(Specify: _____)**
   - Clergy or faith-based professional
   - Community health worker (includes peer educator or navigator)
   - Counselor
   - Dentist
   - Other dental professional
   - Dietitian or nutritionist
   - Midwife
   - Nurse practitioner
   - Nurse
   - Physician
   - Physician assistant
   - Psychologist
   - Social worker
   - Substance use disorder professional
   - Other allied health professional (e.g., medical assistant, physical therapist, etc.), **(Specify: _____)**
   - Other clinical professional (e.g., podiatrist, chiropractor, etc.), **(Specify: _____)**
   - Other public health professional, **(Specify: _____)**

5. **Your primary functional role (e.g., job title). Select one.**
   - Administrator
   - Agency board member
   - Care provider/clinician – does not prescribe HIV treatment
   - Care provider/clinician – prescribes HIV treatment
   - Case manager

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- City, local, or state government employee
- Client educator (includes navigator)
- Clinical/medical assistant
- Federal government employee
- Health care organization non-clinical staff (e.g., front desk, etc.)
- HIV tester
- Intern/resident
- Practice administrator or organizational leadership (e.g., chief executive officer, nurse administrator, etc.)
- Researcher/evaluator
- Student/graduate student
- Teacher/faculty
- Other, (**Specify: _____**)

6. **Are you currently or have you ever received a scholarship or loan repayment of any of the following HRSA-funded programs? Select one.**
   - National Health Service Corp scholarship
   - National Health Service Corps loan repayment
   - Nurse Corps scholarship
   - Nurse Corps loan repayment

7. **What is your current training track? Select one.**
   - Training Track 1
   - Training Track 2
   - Training Track 3
   - Training Track 4
   - Training Track 5
   - Training Track 6
   - Training Track 7

8. **Provide the date (Month and Year) you started your current training track?**

M	M	Y	Y	Y	Y

9. **Are you currently participating in an HIV Interprofessional Education (IPE) program?**
   - Yes
   - No **(Skip to question 12)**

10. **Type of academic program currently enrolled? Select one.**
    - Associates
    - Bachelors
    - Masters (e.g., MPH, MSN, MSW, etc.)
    - MD/PA
    - DDS/DMD
    - Doctoral (e.g., PhD, DrPH, DNP, PharmD, etc.)
    - Other, **(Specify: _____)**

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11. **Expected graduation/completion year (YYYY)**

12. **What is your race and/or ethnicity. Select all that apply.**
    - **American Indian/Alaska Native** (e.g., Navajo Nation, Blackfeet Tribe Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.)
    - **Asian** (e.g., Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.)
    - **Black or African American** (e.g., African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.)
    - **Hispanic or Latino** (e.g., Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.)
    - **Middle Eastern or North African** (e.g., Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.)
    - **Native Hawaiian or Pacific Islander** (e.g., Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.)
    - **White** (e.g., English, German, Irish, Italian, Polish, Scottish, etc.)

13. **What best describes your gender identity? Select one.**
    - Man
    - Woman
    - Transgender man
    - Transgender woman
    - Other gender identity
    - Choose not to disclose

14. **Which of the following best describes your primary employment setting? Select one.**
    - Academic health center
    - Correctional facility
    - Dental health facility
    - Emergency department
    - Family planning clinic
    - Federally qualified health center (FQHC)
    - Health maintenance organization (HMO)/managed care organization
    - HIV or infectious diseases clinic
    - Hospital-based clinic
    - Indian health services/tribal clinic
    - Long-term nursing facility
    - Maternal/child health clinic
    - Military or veterans' health facility
    - Other community-based organization
    - Other federal health facility
    - Pharmacy
    - Private practice
    - Sexually transmitted infection (STI) clinic

Insert OMB statement here

- State or local health department
- Student health clinic
- Substance use treatment center
- Other primary care setting
- Primary employment setting does not involve direct provision of care or services **(Stop here. You are done with this form.)**
- I am not working **(Stop here. You are done with this form.)**

15. Primary work site ZIP code(s) (provide up to three (3)):

16. Does your primary employment setting receive Ryan White HIV/AIDS Program funding?

- Yes
- No

17. Is HIV care and treatment provided by your primary employment setting?

- Yes
- No

18. Do you provide services directly to clients?

- Yes
- No

19. Do you provide services directly to clients with HIV?

- Yes
- No **(Skip to question 25)**

20. Do you provide HIV prevention counseling services to clients?

- Yes
- No

21. Do you provide HIV testing services to clients?

- Yes
- No

22. Do you prescribe HIV pre-exposure prophylaxis (PrEP) to clients?

- Yes
- No

23. Do you prescribe antiretroviral therapy (ART) to clients with HIV?

- Yes **(Skip to question 25)**

- No

24. **Which of the following best describes the way you provide services directly to client with HIV? Select one.**
    - Non-clinical support services, but not antiretroviral therapy (e.g., case management, transportation, legal, etc.) **(Skip to question 27)**
    - Clinical services to people with HIV, but not antiretroviral therapy (e.g., counseling, cognitive behavioral therapy, nutrition, physical therapy, psychiatry, general primary care, etc.)

25. **What is your level of practice? Select one.**
    - Basic HIV care and treatment
    - Intermediate HIV care and treatment
    - Advanced HIV care and treatment
    - Expert HIV care and treatment, including training others and/or clinical consultation

26. **How many YEARS have you been providing services directly to clients with HIV? Round up to the nearest whole year. If less than one year, write "01."**

27. **Estimate the NUMBER of clients with HIV to whom you provided services directly in the past YEAR.**

For questions 28-33, <u>estimate the percentage</u> of your clients in the past YEAR in each category.

28. **Estimate the PERCENTAGE of your clients in the past YEAR who are receiving antiretroviral therapy (ART). Select one.**
    - None
    - 1-24%
    - 25-49%
    - 50-75%
    - ≥75%
    - Don't know/unsure

29. **Estimate the PERCENTAGE of your clients in the past YEAR who do NOT identify as only White. Select one.**
    - None
    - 1-24%
    - 25-49%
    - 50-75%
    - ≥75%
    - Don't know/unsure

Insert OMB statement here

30. **Estimate the PERCENTAGE of your clients in the past YEAR who are LGBTQ+. Select one.**
    - None
    - 1-24%
    - 25-49%
    - 50-75%
    - ≥75%
    - Don't know/unsure

31. **Estimate the PERCENTAGE of your clients in the past YEAR who are experiencing homelessness or unstable housing. Select one.**
    - None
    - 1-24%
    - 25-49%
    - 50-75%
    - ≥75%
    - Don't know/unsure

32. **Estimate the PERCENTAGE of your clients in the past YEAR with substance use disorder. Select one.**
    - None
    - 1-24%
    - 25-49%
    - 50-75%
    - ≥75%
    - Don't know/unsure

33. **Estimate the PERCENTAGE of your clients with HIV in the past YEAR with a mental illness. Select one.**
    - None
    - 1-24%
    - 25-49%
    - 50-75%
    - ≥75%
    - Don't know/unsure

34. **Estimate the PERCENTAGE of your clients in the past YEAR with hepatitis B or hepatitis C. Select one.**
    - None
    - 1-24%
    - 25-49%
    - 50-75%
    - ≥75%
    - Don't know/unsure

35. **Estimate the PERCENTAGE of your clients with HIV in the past YEAR with a sexually transmitted infection (STI). Select one.**
    - None

Insert OMB statement here

- 1-24%
- 25-49%
- 50-75%
- ≥75%
- Don’t know/unsure