

**CDC National Network of STD/HIV Prevention Training Centers
PARTICIPANT INFORMATION FORM**

Today's date _____
Course title STD Update Course date August 29-30, 2006

First name _____ Middle Initial _____ Last name _____
Degree _____ Title/Position _____
Organization _____
Address _____
City _____ State _____ Zip _____ Country (if not US) _____
Daytime Phone _____ Alt Phone _____ E-mail _____

To create your unique ID number, use 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 has the ID number JOSM0529	_ _ # # <small>(first 2 letters of your first name)</small>	_ _ # # <small>(first 2 letters of last name)</small>	_ _ M M <small>(Month of birth)</small>	_ _ D D <small>(Day of birth)</small>

1. Your gender: Female Male Transgender
2. Your ethnicity (select one): Hispanic or Latino Not Hispanic or Latino
3. Your racial background (select one or more):
 American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White
4. Your occupation classification (select one):
 Clinical/laboratory..... Answer questions 5-6
 Non-clinical..... Answer questions 7-8

<ol style="list-style-type: none"> 5. Your profession (select one): <input type="checkbox"/> Advanced practice nurse <input type="checkbox"/> Registered nurse <input type="checkbox"/> LPN/LVN <input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Laboratorian <input type="checkbox"/> Other: _____ 6. Your primary functional role (select one): <input type="checkbox"/> Clinician <input type="checkbox"/> Administrator <input type="checkbox"/> Supervisor <input type="checkbox"/> Program manager/coordinator <input type="checkbox"/> Case manager <input type="checkbox"/> Prevention case manager <input type="checkbox"/> Counselor <input type="checkbox"/> Researcher <input type="checkbox"/> Resident/fellow <input type="checkbox"/> Laboratorian <input type="checkbox"/> Student <input type="checkbox"/> Faculty <input type="checkbox"/> Health educator <input type="checkbox"/> Trainer <input type="checkbox"/> Outreach <input type="checkbox"/> Disease intervention/investigation <input type="checkbox"/> Not employed <input type="checkbox"/> Other: _____ 	Clinical/Laboratory
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<ol style="list-style-type: none"> 7. Your profession (select one) <input type="checkbox"/> Epidemiologist <input type="checkbox"/> Community health worker <input type="checkbox"/> Disease intervention specialist/investigator <input type="checkbox"/> Health educator <input type="checkbox"/> Social worker <input type="checkbox"/> Behavioral scientist <input type="checkbox"/> Counselor <input type="checkbox"/> Administrator <input type="checkbox"/> Mental health therapist <input type="checkbox"/> Other: _____ 8. Your primary functional role (select one): <input type="checkbox"/> Administrator <input type="checkbox"/> Supervisor <input type="checkbox"/> Program manager/coordinator <input type="checkbox"/> Case manager <input type="checkbox"/> Prevention case manager <input type="checkbox"/> Counselor <input type="checkbox"/> Researcher/epidemiologist <input type="checkbox"/> Resident/fellow <input type="checkbox"/> Student <input type="checkbox"/> Faculty <input type="checkbox"/> Health educator <input type="checkbox"/> Trainer <input type="checkbox"/> Outreach <input type="checkbox"/> Disease intervention/investigation <input type="checkbox"/> Not employed <input type="checkbox"/> Other: _____ 	Non Clinical
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9. Location of your principal employment setting: State or territory: _____ Zip Code: _____

10. Your principal employment setting (select one):
 State/local health department Solo/group private medical practice HMO/managed care organization
 Hospital or hospital-affiliated clinic Community/non-profit health center/clinic
 Community-based service organization (CBO) Correctional facility Tribal/Indian Health Service
 School/university (academic department) School/university (student health clinic) Capacity-Building Assistance (CBA) provider Military Not employed Other: _____

a. If your principal employment setting is a Community Based Organization (CBO), please specify how your agency is funded:

- Directly funded by CDC – program announcement 04064 Directly funded by CDC – program announcement 03003 Other CDC program announcement (please specify): _____
 Health department Other: _____

b. If your organization receives CDC funding to provide Capacity Building and Technical Assistance (CBA provider), please specify how your agency is funded:

- Directly funded by CDC - program announcement 05051 Directly funded by CDC - program announcement 04019 Other CDC program announcement (please specify): _____
 Health department Other: _____

11. Primary programmatic focus of your work: (select up to two):

- STD HIV/AIDS Women's reproductive health General medicine or Family practice
 Adolescent/student health Mental health Substance use/addiction Emergency medicine
 Corrections Other _____

12. Special population(s) or target group(s) focused on by your work/program (select up to three):

- No target group/general Adolescents Gay/Lesbian/Bisexual/MSM Transgender Homeless
 Incarcerated individuals/parolees Pregnant women Sex workers African Americans Asians
 Native Hawaiian/other Pacific Islanders American Indian/Alaska Native Hispanic/Latinos Recent immigrants/refugees Substance users/IDU Substance users/non-IDU HIV+ individuals
 Other special population: _____

13. How did you hear about this course?

- Flyer/brochure Word of mouth/colleague E-mail Notice in newsletter/journal
 Website/internet Conference exhibit Previous PTC course Program requirement
 Other: _____

14. Do you consent to being contacted for:

- Updates? Yes No
Evaluation purposes? Yes No

Public Burden Statement: The information on this form is collected under the authority of 42 U.S.C., Section 243 (CDC). The requested information is used only 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. Furnishing the information requested on this form is voluntary.

Public reporting burden of this collection of information is estimated to average 5 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 (0920-0017).

Return completed application to:
Annabeth Elliott
Idaho Department of Health and Welfare
450 W. State Street, 4th Floor
Boise, ID 83720
or by fax to: 208-332-7346

Local Use Only:

EventID: _____