

**GROUP PARTICIPATION FORM
AHEC CONTINUING PROFESSIONAL EDUCATION**



AHEC is required to report general demographic information about participants in the categories below. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.

PROGRAM INFORMATION

Program Title:	Program Date:	Program Length/Total Hours:
Program Location (Address):		
City:	State:	Zip code:
Sponsoring Institution:		Continuing Education Contact Hours:
Preceptor Info: (# of Preceptors, Name &/or contact info, primary discipline if available.)		

ATTENDEE INFORMATION

Profession: Enter total number of participants per category:

#	Category	#	Category	#	Category
	Administrator		Licensed Practical Nurse		Pharmacy
	Dentistry		M.D.		Physical Therapy
	Dietary/Dietetics		Nurse Assistant		Physician Assistant
	D.O.		Nurse - Practitioner		Radiology Technician
	EMT		Nurse – Registered		Social Work/Mental Health
	Educator (K-12)		Occupational Therapy		Speech Therapy
	Educator (College Level)		Paramedic		Other _____

CE/CME Credits: Maximum credit awarded by category:

#	Category	#	Category
	Allied Health (OT & PT)		Nurse (BSN, RN, LPN)
	Community Health Worker (Admin. EMT, etc.)		Nurse Practitioner (NP)
	Consumer		Pharmacy
	Dentistry		Physician Assistant
	Mental Health (Social Worker, etc.)		Physician (D.O. and M.D.)

FOR OFFICE USE ONLY

Program Location Information

Site Type: Clinic Hospital Nursing Home Unknown Other _____

Program Site Designated Area: HPSA 50% Medicare/Medicaid Other Medically Underserved Area
 Urban Area with 50%+ Medicaid or Uninsured Not a Medically Underserved Area

Reviewing AHEC Staff Member: _____ **Date:** _____

Data Entry: _____ **Date:** _____