

**INDIVIDUAL PARTICIPANT 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

ATTENDEE INFORMATION

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. Name (Last, First, MI):			Suffix or Credential:
Street Address:	City:	State:	Zip code:
Name of Employment:			
Employment Address:	Emp. City:	Emp. State:	Emp. Zip code:
Race / Ethnicity Information (check one): <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian: underrepresented (i.e., Cambodia, Malaysia, Pakistan, Vietnam) <input type="checkbox"/> Asian: Non-underrepresented (i.e., China, Philippine, Japan, Korea, India, Thailand)			<input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White (Disadvantaged) <input type="checkbox"/> White (Non-Disadvantaged)
			Date of Birth: _____ / ____ / ____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female SS #: XXX-XX-____

PROFESSIONAL STATUS

Title/ Position:	Specialty:																								
Current Professional Status: <input type="checkbox"/> Practicing Professional <input type="checkbox"/> Resident <input type="checkbox"/> Retired <input type="checkbox"/> National Health Corps Assignee	Discipline (choose one category): <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Administrator</td> <td><input type="checkbox"/> Nurse – Bachelors Degree</td> <td><input type="checkbox"/> Physician Assistant</td> </tr> <tr> <td><input type="checkbox"/> Community Health Worker</td> <td><input type="checkbox"/> Nurse – Other</td> <td><input type="checkbox"/> Public Health</td> </tr> <tr> <td><input type="checkbox"/> Dental Hygienist</td> <td><input type="checkbox"/> Occupational Therapy</td> <td><input type="checkbox"/> Radiation Technician</td> </tr> <tr> <td><input type="checkbox"/> Dietary/Dietetics</td> <td><input type="checkbox"/> Paramedic</td> <td><input type="checkbox"/> Speech Therapy</td> </tr> <tr> <td><input type="checkbox"/> Emergency Medical Technician</td> <td><input type="checkbox"/> Pharmacy</td> <td><input type="checkbox"/> Social Work/Mental Health</td> </tr> <tr> <td><input type="checkbox"/> Licensed Practical Nurse</td> <td><input type="checkbox"/> Physical Therapy</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Nurse Practitioner</td> <td><input type="checkbox"/> Physician - Allopathic</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Nurse – Registered</td> <td><input type="checkbox"/> Physician - Osteopathic</td> <td></td> </tr> </table>	<input type="checkbox"/> Administrator	<input type="checkbox"/> Nurse – Bachelors Degree	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Community Health Worker	<input type="checkbox"/> Nurse – Other	<input type="checkbox"/> Public Health	<input type="checkbox"/> Dental Hygienist	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Radiation Technician	<input type="checkbox"/> Dietary/Dietetics	<input type="checkbox"/> Paramedic	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Emergency Medical Technician	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Social Work/Mental Health	<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Other _____	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Physician - Allopathic		<input type="checkbox"/> Nurse – Registered	<input type="checkbox"/> Physician - Osteopathic	
<input type="checkbox"/> Administrator	<input type="checkbox"/> Nurse – Bachelors Degree	<input type="checkbox"/> Physician Assistant																							
<input type="checkbox"/> Community Health Worker	<input type="checkbox"/> Nurse – Other	<input type="checkbox"/> Public Health																							
<input type="checkbox"/> Dental Hygienist	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Radiation Technician																							
<input type="checkbox"/> Dietary/Dietetics	<input type="checkbox"/> Paramedic	<input type="checkbox"/> Speech Therapy																							
<input type="checkbox"/> Emergency Medical Technician	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Social Work/Mental Health																							
<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Other _____																							
<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Physician - Allopathic																								
<input type="checkbox"/> Nurse – Registered	<input type="checkbox"/> Physician - Osteopathic																								
Place of Employment: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Community Health Center</td> <td><input type="checkbox"/> Federally Qualified Health Center</td> <td><input type="checkbox"/> National Health Service Center or Tribal Health Site</td> </tr> <tr> <td><input type="checkbox"/> Migrant Health Center</td> <td><input type="checkbox"/> Private Practice</td> <td><input type="checkbox"/> Governor Designated Area Ambulatory Practice Site</td> </tr> <tr> <td><input type="checkbox"/> Healthcare for the Homeless</td> <td><input type="checkbox"/> Health Department</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> Public Housing Primary Care</td> <td><input type="checkbox"/> Urban Clinic</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Rural Health Clinic</td> <td><input type="checkbox"/> Federal Designated Health Profession Shortage Area</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Academic Practice</td> <td><input type="checkbox"/> Hospital (Name) _____</td> <td></td> </tr> </table>		<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Federally Qualified Health Center	<input type="checkbox"/> National Health Service Center or Tribal Health Site	<input type="checkbox"/> Migrant Health Center	<input type="checkbox"/> Private Practice	<input type="checkbox"/> Governor Designated Area Ambulatory Practice Site	<input type="checkbox"/> Healthcare for the Homeless	<input type="checkbox"/> Health Department	<input type="checkbox"/> Other _____	<input type="checkbox"/> Public Housing Primary Care	<input type="checkbox"/> Urban Clinic		<input type="checkbox"/> Rural Health Clinic	<input type="checkbox"/> Federal Designated Health Profession Shortage Area		<input type="checkbox"/> Academic Practice	<input type="checkbox"/> Hospital (Name) _____							
<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Federally Qualified Health Center	<input type="checkbox"/> National Health Service Center or Tribal Health Site																							
<input type="checkbox"/> Migrant Health Center	<input type="checkbox"/> Private Practice	<input type="checkbox"/> Governor Designated Area Ambulatory Practice Site																							
<input type="checkbox"/> Healthcare for the Homeless	<input type="checkbox"/> Health Department	<input type="checkbox"/> Other _____																							
<input type="checkbox"/> Public Housing Primary Care	<input type="checkbox"/> Urban Clinic																								
<input type="checkbox"/> Rural Health Clinic	<input type="checkbox"/> Federal Designated Health Profession Shortage Area																								
<input type="checkbox"/> Academic Practice	<input type="checkbox"/> Hospital (Name) _____																								
Signature:	Date:																								

FOR OFFICE USE ONLY

Program Title:	Program Hours:
Program Location Information Site Type: <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	
Program Site Designated Area: <input type="checkbox"/> HPSA <input type="checkbox"/> 50% Medicare/Medicaid <input type="checkbox"/> Other Medically Underserved Area <input type="checkbox"/> Urban Area with 50%+ Medicaid or Uninsured <input type="checkbox"/> Not a Medically Underserved Area	
Attendee Site Type: <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	
Attendee Site Designated Area: <input type="checkbox"/> HPSA <input type="checkbox"/> 50% Medicare/Medicaid <input type="checkbox"/> Other Medically Underserved Area <input type="checkbox"/> Urban Area with 50%+ Medicaid or Uninsured <input type="checkbox"/> Not a Medically Underserved Area	
Reviewing AHEC Staff Member:	Date:
Data Entry:	Date: