

CHART PARTICIPANT REGISTRATION FORM

What are your current job responsibilities? <input checked="" type="checkbox"/> Check one in each category, if applicable.
1) Primary <input type="checkbox"/> Direct service provider <input type="checkbox"/> Trainer, Educator <input type="checkbox"/> Administrator/Manager <input type="checkbox"/> Other, please specify:
2) Secondary <input type="checkbox"/> Direct service provider <input type="checkbox"/> Trainer, Educator <input type="checkbox"/> Administrator/Manager <input type="checkbox"/> Other, please specify:

Are you currently caring for any HIV/AIDS patients? Yes No

If yes, how many HIV patients do you see in a typical week?

How many of the patients you are caring for are on ARVs?

Do you currently provide any clinical services for STI, TB or other OIs?
 Yes No

If yes, what clinical services do you provide?

The following information to be completed by Trainer and Training Program staff:

Scores (if applicable):	%	Course Participation Costs:	Funded By:
Pre-Training Score:		Subsistence/Per Diem:	
Post-Training Score:		Time Off:	
<input type="checkbox"/> Not Applicable		Tuition:	
		Other:	
		Total:	

Participant did not complete activity

Explain:

Participant shows interest in being a (Check all that apply):

- Clinical trainer
- Classroom trainer

Comments regarding this participant: _____

Trainer Name: _____ **Trainer Signature:** _____