CHART PARTICIPANT REGISTRATION FORM

To be completed by the Participant:

_____

First Name *Last Name* *MI* *DOB (DD/MM//YYYY)*

Gender: ☐ M ☐ F

Name of Course: _____ *Date of Course:*_____

PLEASE COMPLETE IF INFORMATION HAS <u>CHANGED</u> OR IF YOU ARE REGISTERING FOR THE <u>FIRST-TIME</u> AS A CHART PARTICIPANT:

Indicate the primary Facility in which you work:

_____

Facility Name *Street/PO Box*

_____

City *Province/County* *Country* *Postal Code*

_____

Professional e-mail *Personal e-mail* *Professional telephone*

Please ☑ Check one of the following to indicate the Facility Type:

☐ Hospital ☐Health Center/Clinic ☐Pharmacy ☐Training Center ☐Medical/Nursing/Other School ☐Other

Facility Sponsor: ☐ Government ☐ NGO/Not-for-Profit ☐ Private/For Profit ☐ Government/NGO

<table>
<tr><th colspan="4">What type of health professional are you? ☑ Check one.</th></tr>
<tr><td>Nurse</td><td>☐ Enrolled/Trained Clinical
☐ Registered
☐ Registered with a Degree
☐ Nurse/ ward assistant
☐ Nurse-Midwife
☐ Midwife
☐ Public Health
☐ Family Nurse Practitioner</td><td>Physician</td><td>☐ Intern/Resident
☐ General
☐ OB/GYN
☐ Internist
☐ Pediatrician
☐ Infectious Disease
☐ Family Practitioner
☐ Public Health</td></tr>
<tr><td>Dental services</td><td>☐ Dentist
☐ Dental hygienist
☐ Dental technician</td><td>Paramedical</td><td>☐ Med Technician
☐ Nursing auxiliary/ ward assistant
☐ Attendants
☐ Nutritionist
☐ Nutrition technician
☐ Contact investigator</td></tr>
<tr><td>Laboratory</td><td>☐ Laboratory Scientist
☐ Phlebotomist
☐ Technologist</td><td>Pharmacy</td><td>☐ Pharmacist
☐ Pharmacist Technician</td></tr>
<tr><td>Health Services Administrator</td><td>☐ Administrator/Manager</td><td rowspan="2">Social Services</td><td rowspan="2">☐ Social Worker
☐ Counselor</td></tr>
<tr><td>Community-based worker</td><td>☐ Accompagnateur/ Community worker
☐ Agent Sante/Health Aide
☐ Agent Femme
☐ Matrones/Traditional Birth Attendant (TBA)</td></tr>
<tr><td>Student</td><td>Please list discipline:_____</td><td>Other</td><td>☐ Other, please specify:</td></tr>
</table>

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What are your current job responsibilities? ☑ Check one in each category, if applicable.
1) Primary
☐ Direct service provider
☐ Trainer, Educator
☐ Administrator/Manager
☐ Other, please specify:
2) Secondary
☐ Direct service provider
☐ Trainer, Educator
☐ Administrator/Manager
☐ 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): **%**
Pre-Training Score:

Post-Training Score:

☐ **Not Applicable**

Course Participation Costs: Funded By:
Subsistence/Per Diem:
Time Off:
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:** _____