



New York State STD/HIV Prevention Training Center

Partner Services and Program Support

Course Registration Form

Course ID	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Student ID	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Course Begin Date	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

This section completed by NYS PTC Staff.

(Please print clearly)

Applicant Information:

First name _____ Middle Initial _____ Last Name _____ Degree _____

Agency or Company Name _____

Department _____

Title _____

Mailing Address _____

City _____ State _____ Zip _____

Phone (_____) _____ Ext _____

Alternate Phone (_____) _____ Fax (_____) _____

Sex M F

Ethnicity (select one): Hispanic or Latino Not Hispanic or Latino

Race (select one or more): White Black or African American Asian
 Native Hawaiian or Other Pacific Islander American Indian or Alaska Native

What is your principal occupation type? (select one)

- | | |
|---|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Administrator |
| <input type="checkbox"/> Physician's assistant | <input type="checkbox"/> Disease Intervention Specialist (DIS) |
| <input type="checkbox"/> Registered nurse | <input type="checkbox"/> Student |
| <input type="checkbox"/> Licensed practical nurse | <input type="checkbox"/> Case manager |
| <input type="checkbox"/> Nurse practitioner | <input type="checkbox"/> Outreach staff |
| <input type="checkbox"/> Certified nurse midwife | <input type="checkbox"/> Community planning |
| <input type="checkbox"/> Laboratorian, medical technologist | <input type="checkbox"/> Social worker |
| <input type="checkbox"/> HIV counselor | <input type="checkbox"/> Drug treatment counselor |
| <input type="checkbox"/> Health educator | <input type="checkbox"/> Other – please specify _____ |

(Continued on next page.)

Student ID	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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In what type of organization are you primarily employed? (select one)

- | | |
|---|---|
| <input type="checkbox"/> Non-clinical care (community-based) organization | <input type="checkbox"/> Clinical laboratory |
| <input type="checkbox"/> Government-funded public health program
(city, county, state or national) | <input type="checkbox"/> Corrections facility |
| <input type="checkbox"/> University, college or other school | <input type="checkbox"/> Military |
| <input type="checkbox"/> Family planning program (not government funded) | <input type="checkbox"/> Indian Health Service |
| <input type="checkbox"/> Managed care organization | <input type="checkbox"/> Migrant health clinic |
| <input type="checkbox"/> Private practice, clinical care org., including hospital/clinic | <input type="checkbox"/> Other – please specify _____ |

What percentage of your principal occupation is devoted to STD/HIV? (select one)

- | | | |
|--------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> 26-50% | <input type="checkbox"/> 76-99% |
| <input type="checkbox"/> 1-25% | <input type="checkbox"/> 51-75% | <input type="checkbox"/> 100% |

How did you hear about this course? (select one)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Flyer/Brochure | <input type="checkbox"/> Word of mouth/Colleague | <input type="checkbox"/> E-mail message | <input type="checkbox"/> Notice in newsletter/journal |
| <input type="checkbox"/> Website/Internet | <input type="checkbox"/> Conference exhibit | <input type="checkbox"/> Other (please specify): _____ | |

E-mail Address _____

Score on Employee Development Guide (EDG) Comprehensive Examination: %

Date of Birth (M/D/Y) ____/____/19____

If you would like to receive information about future trainings at your home address, please enter your address:

Supervisor Information:

First name _____ Last Name _____ Title _____

Phone (_____) _____ Fax (_____) _____

Mailing Address _____

Program Manager Information:

First name _____ Last Name _____ Title _____

Phone (_____) _____ Fax (_____) _____

Mailing Address _____

Please return completed form to:
Charlene Cutting, NYS STD/HIV Prevention Training Center, NYS Department of Health, Bureau of STD Control,
Empire State Plaza, Corning Tower, Room 1142, Albany, NY 12237-0670.
Phone: 518/474-1692; Fax: 518/402-5075. Thank you!