

**Southeast / South Central Health Education Center
Individual Form
Continuing Professional Education**

FORM - F (03/05)

The NWI Area Health Education Center 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.

TITLE OF PROGRAM Spring Into Quality Symposium
PROGRAM DATES March 4, 2010
PROGRAM LOCATION (Town/City & Zip) Plainfield, Indiana 46168

Attendee Address(home):

Last Name _____ **First Name** _____ **MI (Maiden Name)** _____ **Ms. Mrs. Mr. Dr. Jr. Sr.**
(circle all that apply)

Address: **Street / Apt#** _____ **City** _____ **State** _____ **Zip Code** _____

Day Phone #: () _____ **Evening Phone #** () _____ **E-Mail:** _____

Date of Birth ____/____/____ **Social Security #** _____ **Gender:** Male Female

Race (Check one)

- American Indian or Alaskan Native
- Asian: (Cambodia, Malaysia, Pakistan, Vietnam)
- Asian: (China, Philippine, Japan, Korea, India, Thailand)
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- More than one race

Ethnicity (check one)

- Hispanic or Latino Not Hispanic or Latino

Professionals (check all that apply)			Students/Trainees use this section	
<input type="checkbox"/> Administrator (health)			<input type="checkbox"/> Nursing School	<input type="checkbox"/> Pre-health professions
<input type="checkbox"/> Guidance Couns.			<input type="checkbox"/> Medical School	<input type="checkbox"/> graduate health professions
<input type="checkbox"/> K-12 Teacher			<input type="checkbox"/> Resident	<input type="checkbox"/> undergraduate health professions
<input type="checkbox"/> Practitioner			<input type="checkbox"/> Fellow	
<input type="checkbox"/> Other			<input type="checkbox"/> Other student: _____	
<input type="checkbox"/> National Health Service Corps (past or current)				

Discipline (check all that apply)	...in other health care	...in allied health
...in primary care	<input type="checkbox"/> Medicine – Allopathic	<input type="checkbox"/> Clinical Lab Sciences
<input type="checkbox"/> Family Medicine	<input type="checkbox"/> Medicine – Osteopathic	<input type="checkbox"/> Food and Nutrition Services
<input type="checkbox"/> General Internal Medicine	<input type="checkbox"/> Nurse Anesthetist	<input type="checkbox"/> Health Information
<input type="checkbox"/> General Pediatrics	<input type="checkbox"/> Nursing – Other Advance Practice Nurse	<input type="checkbox"/> Rehabilitation
<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Nursing (RN) <input type="checkbox"/> Nursing (all other)	<input type="checkbox"/> Technicians and Technologists
<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Dental Hygienist
<input type="checkbox"/> Nurse Midwives	<input type="checkbox"/> Dental Public Health	<input type="checkbox"/> Assistants
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Health Administration	
<input type="checkbox"/> Podiatric Medicine – Primary Care	<input type="checkbox"/> Public Health	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Preventive Medicine	
	<input type="checkbox"/> Pharmacy	
	<input type="checkbox"/> Clinical Psychology / Mental Health	
	<input type="checkbox"/> Social Work / Community Health Worker	

Place of Employment (check all that apply)

- Community Health Center
- Migrant Health Center
- Health Care for Homeless grantee
- Public Housing Primary Care Grantee
- Rural Health Clinic
- National Health Service Corps Site
- Indian Health Service Center or Tribal Health Site
- Federally Qualified Health Center
- Federally Designated Health Profession Shortage Area
- Health Department
- Governor Designated Ambulatory Practice Site
- Urban Clinic (serving 50% or more Medicaid or uninsured)
- Private Practice
- Academic Practice
- Hospital (please name) _____
- Ambulatory
- Inpatient
- Other _____

Name of Employment:

Site or Employer Address

Address:	Street / Suite#	City	County	State	Zip Code
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The SE/SC AHEC is required to report general demographic information about participants in the categories above. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs.

This information will not be made available to any other agency. We appreciate your cooperation in the completion of this form.

I understand the above information will be maintained confidentially and used for program monitoring and evaluation purposes only. I attest to the accuracy of the information that I have given.

Signature	Date
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FOR OFFICE USE ONLY

Reviewing AHEC Staff Member: _____	Date: _____
Data Entry Staff Member: _____	Date: _____