

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0281, and the expiration date is 07/31/2013. Public reporting burden for this collection of information is estimated to average 0.167 hours per respondent annually, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.

**HRSA AIDS Education and Training Centers
Participant Information Form (PIF)**

To create your unique ID number, use the month of your birth, the day of your birth, and the last four digits of your social security number. For example, May 29, 123-45-6789 has the ID number 05296789.

1.

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M M D D # # # #
Unique ID Number

2.

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M M / D D / Y Y
Today's Date

- 3. Your Primary Profession/Discipline (Select one)**
- 1. Dentist
 - 2. Other Dental Professional
 - 3. Advanced Practice Nurse
 - 4. Nurse
 - 5. Pharmacist
 - 6. Physician
 - 7. Physician Assistant
 - 8. Clergy/Faith-Based Professional
 - 9. Dietitian/Nutritionist
 - 10. Health Educator
 - 11. Mental/Behavioral Health Professional
 - 12. Other Public Health Professional
 - 13. Social Worker
 - 14. Substance Abuse Professional
 - 15. Community Health Worker
 - 16. Other non-clinical professional (specify): _____

- 4. Your Primary Functional Role (Select one)**
- 1. Administrator
 - 2. Agency Board Member
 - 3. Care Provider/Clinician
 - 4. Case Manager
 - 5. Client/Patient Educator
 - 6. Clinical/Medical Assistant
 - 7. Intern/Resident
 - 8. Researcher/Evaluator
 - 9. Student/Graduate Student
 - 10. Teacher/Faculty
 - 11. Other (specify): _____

- 5. Your Principal Employment Setting (Select one)**
- 1. Academic Health Center
 - 2. Community Health Center
 - 3. Family Planning Clinic
 - 4. HIV Clinic
 - 5. HMO/Managed Care Organization
 - 6. Hospital-Based Clinic
 - 7. Hospital/ ER
 - 8. Indian Health Services/Tribal Clinic
 - 9. Infectious Disease Clinic
 - 10. Long-Term Nursing Facility
 - 11. Maternal/Child Health Clinic
 - 12. Mental/Behavioral Health Clinic
 - 13. Rural Health Clinic
 - 14. Sexually Transmitted Disease Clinic
 - 15. Substance Abuse Treatment Center
 - 16. College/University
 - 17. Community-Based Organization
 - 18. Community/retail pharmacy
 - 19. Correctional Facility
 - 20. Military/VA
 - 21. Private Practice
 - 22. State/Local Health Department
 - 23. Non-Health
 - 24. Other Primary Care
 - 25. Not working (skip to Q. #9)

- 6a. Primary Employment Setting**
- Rural Suburban/urban
- 6b. Zip code**

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- 7. Is the employment setting a faith-based organization?**
- Yes No Don't Know
- 8a. Does the employment setting receive Ryan White Program funding?**
- Yes (skip to Q9.) No (skip to Q9) Don't Know (go to Q 8b.)
- 8b. If 8a=Don't Know, please write the full name of your agency:**
- _____

NOTE: Please answer BOTH Question 9 about Hispanic origin and Question 10 about race.

- 9. Are you of Hispanic, Latino/a, or Spanish origin?**
- Yes No
- 10. What is your racial background? (Select all that apply?)**
- American Indian or Alaska Native
 - Asian
 - Black or African American
 - Native Hawaiian or Other Pacific Islander
 - White
- 11. What is your gender?**
- Female
 - Male
 - Transgender
- 12a. Do you provide services directly to clients/patients?**
- Yes No (Stop here. You are done with this form.)
- 12b. Please estimate the PERCENTAGE of your OVERALL CLIENT/PATIENT population in the past YEAR who were racial-ethnic minorities:**
- None/yr. 1-24%/yr. 25-49%/yr. 50-74%/yr. ≥75%/yr.
-

- 13. Do you provide services directly to HIV-infected clients/patients?**
- Yes No/Don't know (Stop here. You are done with this form.)
- 14. How many YEARS have you been providing services directly to HIV-infected clients/patients?**
- | | |
|--|--|
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 (Round up to the nearest whole year.)
- 15. Estimate the NUMBER of HIV-infected clients/patient to whom you provide direct services in an average MONTH.**
- None/mo. 1-9/mo. 10-19/mo. 20-49/mo. 50+/mo.
-

For Questions 16 through 19, estimate the PERCENTAGE of your HIV-infected clients/patients in the past YEAR who were:

- 16. HIV+ who are racial-ethnic minorities**
- None/yr. 1-24%/yr. 25-49%/yr. 50-74%/yr. ≥75%/yr.
-
- 17. HIV+ who are co-infected with Hepatitis C**
- None/yr. 1-24%/yr. 25-49%/yr. 50-74%/yr. ≥75%/yr.
-
- 18. HIV+ who are receiving antiretroviral therapy**
- None/yr. 1-24%/yr. 25-49%/yr. 50-74%/yr. ≥75%/yr.
-
- 19. HIV+ who are women**
- None/yr. 1-24%/yr. 25-49%/yr. 50-74%/yr. ≥75%/yr.
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