CONTINUING EDUCATION PARTICIPANT PROFILE FORM

TITLE OF PROGRAM: _____

DATE(S): _____ _____

Please Legibly Write-In or Check Appropriate Box Below. Thank you!

Participant Name:			
Participant Type: □Health Professional □HP Student □Consumer/Lay Worker □Teacher/Counselor			
Profession:		Specialty:	
School Attended:		Program of Study:	
Place of Employment:		Medicaid Provider □Yes □No	
Employment Mailing Address:			
City:	State:	Zip Code:	County of Employment: _____ County of Residence: _____
Phone:	Fax:	Email:	

GENDER: □Male □Female

AGE RANGE: □Under 20 □20-29 □30-39 □40-49 □50-59 □60 +

ETHNICITY:

□African-American □Caucasian
□American Indian □Hispanic/Latino
□Asian □Other (please specify) _____

ARE YOU A CURRENT OR PAST RECIPIENT OF NATIONAL HEALTH SERVICE CORPS FUNDS?
□YES □NO

DOES THIS PROGRAM APPLY TO YOUR STATE LICENSURE OR CERTIFICATION REQUIREMENTS?
□YES □NO

HOW MANY CME/CE HOURS DID YOU RECEIVE AT THIS EVENT? _____

DO YOU PLAN TO USE ANY OF THE INFORMATION PROVIDED IN YOUR PRACTICE/STUDY/OR SCHOOL?
□YES *(if yes, how?)* _____
□NO

***Please check all topics you would like to be considered for future programming.**

□Adolescent Health □Asthma □Bioterrorism □Cancer □Cardiovascular Disease □Diabetes □Geriatrics □HIV/AIDS □Maternal and Child Health □Men's Health □Mental Health □Obesity □Oral Health □STDs □Tuberculosis □Women's Health
□Other (*please list)*_____

AHEC OFFICE USE ONLY

Database Entry Date:	Entered By: