Tuesday, April 4, 2006 ◆ 8.00–5.00 p.m. ◆ Double Tree Hotel, San Jose

HIV Care & Prevention 2006

A regional conference for physicians, nurse practitioners, prevention specialists, and other health care providers

Deadline to Register Online or by Fax: Friday, March 17, 2005

1. Name: _____

○ RN ○ NP ○ LMFT ○ LSW ○ DDS ○ LVN ○ MD ○ PA ○ MA ○ Pharm D

2. Address: _____
3. City: _____ State: _____ Zip: _____
4. Phone: _____ 5. Fax: _____
6. Email: _____
7. Where do you work?

○ Santa Clara Valley Health & Hospital System

○ Other: _____

8. Please choose one workshop you plan to attend for each breakout session:

Workshop Session 1 (9:30–11:00)

○ Update on State of the Art Antiretroviral Treatment and Management

○ HIV & Psychiatric Illness

○ Transgender Awareness for HIV Healthcare Providers: Understanding the Trans in Transgender

Workshop Session 2 (11:10-12:40)

○ Co-morbidities and HIV

○ Oral Health Screening & Dental Referrals: Issues for the Primary Care Provider

○ HIV & Women: Improving the Quality of Prevention and Care

Workshop Session 3 (1:40–3:10)

○ Pain Control in HIV Patients

○ Recognizing Acute HIV Infection: Issues for the Primary Care Provider

○ Advancing Prevention Strategies to Respond to HIV/AIDS Issues in the AAPI Community

Workshop Session 4 (3:20–4:50)

○ Partner Notification as HIV Prevention

○ STD Overview for the HIV Care Provider

○ Sex, Meth, & HIV

9. Do you want to receive Continuing Education Units (CEUs)? ○ Yes ○ No

If yes, which*? ○ RN ○ LMFT ○ LSW ○ MD *License Number: _____

10. Registration Fees: $50 general admission payment options:

○ Check payable to "Community Health Partnership" (Check # or PO # _____)

Send to: Community Health Partnership, HIV Care & Prevention 2006, PO Box 21940, San Jose, CA 95151

○ Visa ○ Master Card ○ Discover ○ American Express

_____ - _____ - _____ - _____ Exp ____/____

Name on card: _____

Billing Address: _____

_____

This is the fax version of the registration form. You will need to bring this, along with a Participant Information Form (PIF) and proof of payment, to the registration table at the conference.

For more Information, visit www.chpscc.org or fax 408.289.9464

Community Health Partnership | Health Education & Training Center | San Jose AIDS Education and Training Center | Santa Clara Valley Medical Center

PIF

HRSA AIDS Education and Training Centers
PARTICIPANT INFORMATION FORM

OMB No. 0915-0281
Expires: 12/31/2006

Please completely fill in the circles (●) when answering the questions.

1. 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.

M	M	D	D	#	#	#	#

Unique ID Number

0	4	/	0	4	/	0	6
M	M		D	D		Y	Y

Today's Date

2. Your Profession/Discipline (Select one)

- ○ Advanced Practice Nurse
- ○ Dentist
- ○ Mental Health Professional
- ○ Nurse
- ○ Nurse Practitioner
- ○ Other Dental Professional
- ○ Pharmacist
- ○ Physician
- ○ Physician Assistant
- ○ Social Worker
- ○ Substance Abuse Professional
- ○ Other(specify)_____

3. Your Primary Functional Role (Select one)

- ○ Administrator/Supervisor
- ○ Care Provider/Clinician
- ○ Case Manager
- ○ Intern/Resident
- ○ Researcher
- ○ Student/Graduate Student
- ○ Teacher/Faculty
- ○ Other (specify) _____
- ○ Not Working

4. Your Principal Employment Setting (Select one)

- ○ Community/Migrant Health Center
- ○ Community Mental Health Center
- ○ Correctional Facility
- ○ HMO/Managed Care Organization
- ○ Hospital or Hospital-Based Clinic
- ○ Rural Health Center
- ○ Solo/Group Private Practice
- ○ State/Local Health Department
- ○ Substance Abuse Treatment Prog.
- ○ STD/Family Planning Clinic
- ○ Tribal/Indian Health Service
- ○ Other Community-Based Service Organization (CBO)
- ○ Other Public Health Agency
- ○ Other Health Care
- ○ Non-health
- ○ Not Working

Questions 5-7 are about your principal employment setting

5. Is it a faith-based organization? ○ Yes ○ No ○ Don't Know

6. Zip Code/Setting

○ Rural ○ Urban

7. Does the agency receive Ryan White CARE Act funding? ○ Yes ○ No ○ Don't Know

7a. If you don't know, write the full name of your employer:

_____

8. Are you of Hispanic, Latino, or Spanish origin?

○ Yes ○ No

8a. Your Racial Background (Select all that apply)

- ○ White
- ○ Black or African American
- ○ Asian
- ○ Native Hawaiian/Other Pacific Islander
- ○ American Indian/Alaska Native

9. Your Gender ○ Female ○ Male ○ Transgender

10. Which of the following statements describes the way in which you most often provide services for HIV/AIDS patients (Select one).

- ○ Not applicable/Do not see patients **(Skip the rest of this form)**
- ○ Refer/transfer HIV+ patients for all medical care
- ○ Provide primary care and refer/transfer HIV+ patients for HIV treatment only
- ○ Provide all HIV treatment and refer/transfer for primary care
- ○ Provide all medical care and refer/transfer when antiretroviral treatment fails
- ○ Provide all medical care throughout the course of the disease

11. Estimate the NUMBER of HIV+ clients/patients you have personally treated/managed in practice in the past month.

○ Don't Know

For questions 12-18, estimate the PERCENTAGE of your HIV+ clients/patients in the past YEAR who were:

	None	1-24%	25-49%	50-74%	≥75%	Don't Know
12. Racial or Ethnic Minorities	○	○	○	○	○	○
13. On Antiretroviral Therapy	○	○	○	○	○	○
14. Severely/Persistently Mentally Ill	○	○	○	○	○	○
15. Substance Users	○	○	○	○	○	○
16. Uninsured	○	○	○	○	○	○
17. Women	○	○	○	○	○	○
18. Incarcerated/Parolees	○	○	○	○	○	○

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 number. The OMB control number for this project is 0915-0281. Public reporting burden for this collection of information is estimated to be 10 minutes per form. These estimates include the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of imformation.

For Office Use Only

May 2004

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AETC		Subsite			Program Number											Agency							

Yes ○ No ○ Don't Know ○

RWCA PAETC PIF 0769-47525-5