National Network of STD Clinical Prevention Training Centers

OMB Control Number 0920-0995
Exp. Date 5/31/2020

NNPTC Abbreviated Health Professional Application for Training

Public reporting burden of this collection of information is estimated to average 3minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0995).

Today's date	Course title				
First name	Last name		Degree		
Position	Work organization name				
Work Address	City	State	County	Zip	Country
E-mail					

Month and *day* of your birth (to create an anonymous unique code for your data). ___ ___ (MM) ___ ___(DD)

1. Your primary profession/ discipline (*select ONE*):
- ☐ Dentist
- ☐ Other dental professional
- ☐ Advanced practice nurse / Nurse Practitioner /Midwife
- ☐ Registered nurse
- ☐ Licensed practical nurse
- ☐ Pharmacist
- ☐ Physician
- ☐ Physician Assistant
- ☐ Clergy/Faith-Based Professional
- ☐ Dietitian/Nutritionist
- ☐ Health Educator
- ☐ Mental health/behavioral health professional
- ☐ Social worker
- ☐ Substance abuse professional
- ☐ Public health worker
- ☐ Other (*please specify*)_____

2. Your primary functional role (*select ONE*):
- ☐ Administrator (director, coordinator, manager, supervisor)
- ☐ Agency Board member
- ☐ Clinician / Nurse / Care provider
- ☐ Case manager
- ☐ Client/patient counselor
- ☐ Client/patient educator
- ☐ Clinical/medical assistant
- ☐ Disease intervention specialist / Partner services provider
- ☐ Intern / resident / fellow
- ☐ Mental/behavioral health therapist
- ☐ Outreach staff
- ☐ Peer support provider
- ☐ Researcher / evaluator
- ☐ Student/Graduate Student
- ☐ Teacher / faculty
- ☐ Trainer / TA Provider
- ☐ Other (*please specify)*_____

3. Your principal employment setting (*select ONE*):
- ☐ Academic Health Center /School- based health center
- ☐ College/University
- ☐ Community-based service organization (CBO)
- ☐ Community health center (e.g. Federally Qualified Health Center)
- ☐ Other non-profit health center
- ☐ Community/retail pharmacy
- ☐ Correctional facility
- ☐ HMO/managed care organization
- ☐ Hospital/Hospital-affiliated clinic
- ☐ Military Health System/ Veterans Health Admin facility
- ☐ Private practice (Solo/group)
- ☐ Rural health center
- ☐ State/local health department
- ☐ Tribal/Indian Health Service facility
- ☐ Non-Health Setting
- ☐ Other *(please specify)*_____
- ☐ Not working

4. Primary programmatic focus of your work (*select up to TWO*):
- ☐ HIV/AIDS
- ☐ STD
- ☐ TB
- ☐ Hepatitis
- ☐ Reproductive health / family planning
- ☐ Recovery support / trauma / domestic violence
- ☐ Labor and delivery
- ☐ Adolescent and/or pediatric health
- ☐ Emergency medicine / urgent care
- ☐ Primary care (e.g. general / family medicine)
- ☐ Mental / behavioral health
- ☐ Oral health
- ☐ Other infectious diseases
- ☐ Other (*please specify*)_____

5. What is your racial background? (*select ALL that apply*)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

6. Are you of Hispanic, Latino/a, or Spanish origin?
- ☐ Yes
- ☐ No

7. What is your gender?
- ☐ Female
- ☐ Male
- ☐ Transgender (female to male)
- ☐ Transgender (male to female)

8. Do you provide direct services to patients / clients who are … (*select ALL that apply*):

ages 15-19	☐No	☐Yes	☐Not now, but expect to in the future
ages 20-24	☐No	☐Yes	☐Not now, but expect to in the future
pregnant women	☐No	☐Yes	☐Not now, but expect to in the future
men who have sex with men	☐No	☐Yes	☐Not now, but expect to in the future

9. Please estimate the NUMBER of clients / patients to whom you provide STD screening, diagnosis, or treatment in an average MONTH.
☐ None/mo. ☐ 1-9/mo. ☐ 10-19/mo. ☐ 20-49/mo. ☐ 50+/mo.

10. Do you use the CDC STD Treatment Guidelines to guide the care of your patients / clients?
- ☐ No, I am not aware of the Guidelines
- ☐ I am aware of the Guidelines but do not use them
- ☐ I use the Guidelines occasionally
- ☐ I use the Guidelines consistently
- ☐ I use another source to guide my STD care (*please specify*)_____

11. Are you aware of the STD Tx Guide mobile app that can be used to access the CDC STD Treatment Guidelines?
- ☐ No, I am not aware of the app
- ☐ I am aware of the app but I do not use it
- ☐ I use the app
- ☐ I use a different app for STD clinical information

Thank You!

National Network of STD Clinical Prevention Training Centers

OMB Control Number 0920-0995
Exp. Date 5/31/2020

TODAY'S DATE		CONFIDENTIAL IDENTIFIER
_____ M M D D Y Y	Your confidential ID number is the first two letters of your FIRST name, the first two letters of your LAST name, the MONTH of your birth, and the DAY of your birth.	FN FN LN LN M M D D

Basic Post-Course Evaluation

Public reporting burden of this collection of information is estimated to average 2 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0995).

1. **How satisfied were you with your overall learning experience?**

very unsatisfied ① ② ③ ④ ⑤ very satisfied

2. **How satisfied were you with the quality of the content?**

very unsatisfied ○ ○ ○ ○ ○ very satisfied

3. **How satisfied were you with the trainer(s)?**

very unsatisfied ○ ○ ○ ○ ○ very satisfied

4. **How satisfied were you with the teaching methods?**

very unsatisfied ○ ○ ○ ○ ○ very satisfied

5. **Was this training free of commercial bias?**

① Yes
⓪ No

6. **Was this training evidence-based?**

① Yes
⓪ No

7a, **Were the learning objectives met?**

① Yes
⓪ No

7b. **If the learning objectives were not met, please explain.**

8. **What could improve this training?**

9a. **As a result of information presented, do you intend to make changes in your practice or at your worksite setting?**

○ Yes
○ No
○ Not my job
○ I already use these practices
○ Other reason (please specify)_____

9b. **If yes, please list at least one intended change.**

10a. **How much did you know about the topics covered in this session BEFORE this training?**

no knowledge ① ② ③ ④ ⑤ all the knowledge

10b. **How much do you know AFTER the training?**

no knowledge ○ ○ ○ ○ ○ all the knowledge