HIV/AIDS ON THE FRONT LINE April 25, 2012

REGISTRATION

REGISTER ONLINE AT: http://www.hivconference.com/registration.htm

Registration includes: program, syllabus, parking, continental breakfast, lunch and accreditation
Each Category 1 CME credit translates into one nursing CEU, other disciplines will receive certificate of attendance

EARLY BIRD DISCOUNT – Registration fee **postmarked on or before March 2** - $160.00 🎗 Postmarked after March 2, $185.00
GROUP DISCOUNTS 🎗 Group discount of five or more $150 per person 🎗 It must be postmarked by March 2, 2011 🎗 Groups must register with **ONLY** **one transaction/payment per group** i.e., one check or one Credit card charge for the whole group 🎗 NO Group cancellations allowed, but you may substitute a participant. **CANCELLATION POLICY:** Cancellation request must be in writing and received by March 2, 2012. A $20.00 administrative fee will apply to all refunds. 🎗 After March 2, 2012 **No refunds** will be accepted, although you may transfer your registration to another person. Thank you for your participation!!

____ CME CEU MFT/LCSW OTHER
(Please Print Clearly) First Name Last Name Certificate Type (circle one)

Position or Title Affiliation (for your name badge)

Home Address – Street

City State Zip Code

E-Mail Address

Work Telephone Number Home Telephone Number Fax Number

Credential Type (circle one) MD DO RN PA NP PharmD LCSW MFT Other (please specify)

MANDATORY for CME/CEU **License Number OR last 5 digits of social security number is required**____________________

Send registration and payment to:	Blanca Guardado - UCI Infectious Diseases - City Tower
Or FAX to (714) 456-7169	101 The City Drive South, City Tower, Suite 400
	Orange, CA 92868-4081
Please make checks payable to:	**UC Regents** Infectious Diseases

For credit card payments please call (714)456-7612 or fax to (714) 456-7169

☐ VISA ☐ DISCOVER ☐ MASTERCARD ☐ AMERICAN EXPRESS

Credit Card Number: ______________________________ Credit Card Expiration Date: ______ /______
(MONTH) (YEAR)
Cardholder Name: ______________________________ Amount Paid: $ ________________
(NAME AS IT APPEARS ON THE CREDIT CARD)
You are hereby authorized to charge my credit card account. **Cardholder Signature:** ______________________________

MEAL: Buffet Style

BREAK OUT SESSIONS – Please choose one topic from each session:

Session I	**Session II**
☐ Gonorrhea & Syphilis in HIV	☐ Sexual Health
☐ The Role of the Pharmacist in HIV	☐ Hepatitis C New Medications
☐ Cultural Stigma & Discrimination	☐ Technology in HIV Care
☐ Biomedical Prevention	☐ HIV Novel Therapies

FOR OFFICE USE ONLY: Date Payment Received: ____________ Amount Received: ___________ Check No.: __________ CC on file _______

PLEASE INCLUDE UNIQUE ID # !!! **Name:**___________________________

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. [ ][ ][ ][ ][ ][ ][ ][ ]
M M D D # # # #
Unique ID Number

2. [ ][ ] / [ ][ ] / [ ][ ]
M M D D Y Y
Today's Date

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

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

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

6a. Primary Employment Setting

O Rural O Suburban/urban

6b. Zip code [ ][ ][ ][ ][ ]

7. Is the employment setting a faith-based organization?

O Yes O No O Don't Know

8a. Does the employment setting receive Ryan White Program funding?

O Yes (skip to Q9.) O No (skip to Q9) O 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?

O Yes O No

10. What is your racial background? (Select all that apply?)
- O American Indian or Alaska Native
- O Asian
- O Black or African American
- O Native Hawaiian or Other Pacific Islander
- O White

11. What is your gender?
- O Female
- O Male
- O Transgender

12a. Do you provide services directly to clients/ patients?

O Yes O 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. O 1-24%/yr. O 25-49%/yr. O 50-74%/yr. O ≥75%/yr. O

13. Do you provide services directly to HIV-infected clients/patients?

O Yes O 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?

[ ][ ] (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. O 1-9/mo. O 10-19/mo. O 20-49/mo. O 50+/mo. O

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. O 1-24%/yr. O 25-49%/yr. O 50-74%/yr. O ≥75%/yr. O

17. HIV+ who are co-infected with Hepatitis C

None/yr. O 1-24%/yr. O 25-49%/yr. O 50-74%/yr. O ≥75%/yr. O

18. HIV+ who are receiving antiretroviral therapy

None/yr. O 1-24%/yr. O 25-49%/yr. O 50-74%/yr. O ≥75%/yr. O

19. HIV+ who are women

None/yr. O 1-24%/yr. O 25-49%/yr. O 50-74%/yr. O ≥75%/yr. O