

# PARTICIPANT PROFILE INFORMATION

## THREE RIVERS AREA HEALTH EDUCATION CENTER

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Title: \_\_\_\_\_

Date: \_\_\_\_\_

*This information is required by our funding sources. We would appreciate your cooperation completing this form. This information is for statistical reasons and will be kept confidential. Thank You.*

NAME: \_\_\_\_\_  
(FIRST NAME) (MIDDLE INITIAL) (LAST NAME)

ADDRESS (HOME) \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP CODE \_\_\_\_\_ HM PHONE #: \_\_\_\_\_ COUNTY OF RESIDENCE: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_

WORK PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

(Circle: Home or Work)

COUNTY OF EMPLOYMENT: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

(Circle: Home or Work)

PLEASE SPECIFY YOUR PROFESSION AND SPECIALITY:

PROFESSION:

SPECIALITY (if applicable):

ARE YOU A STUDENT (Circle)? YES NO

ARE YOU A HEALTH OCCUPATION TEACHER (Circle)? YES NO

ETHNICITY (Check one):  Caucasian  African-American  Asian  Hispanic/Latino  
 American Indian  Pacific Islander  
 Other (please specify) \_\_\_\_\_  Prefer to not answer

AGE (Check one):  UNDER 20  20-29  30-39  40-49  50-59  60 and over  No response

GENDER (CIRCLE): Male Female

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

DOES YOUR PLACE OF EMPLOYMENT ACCEPT MEDICAID PATIENTS? YES NO

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

List any other programs you are interested in:

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