

**State of Connecticut
Department of Public Health
Training Registration Form**

Please complete and reply by e-mail to marianne.buchelli@ct.gov OR
By fax to 860 – 509 – 7855 or 7853/ Attn: Training Program Staff

Date	First Name	Last Name	Role/Title
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender		
Race/ethnicity	<input type="checkbox"/> African-American <input type="checkbox"/> Asian-American <input type="checkbox"/> Caucasian <input type="checkbox"/> Puerto-Rican <input type="checkbox"/> Hispanic/Latino/a <input type="checkbox"/> Native-American <input type="checkbox"/> Pacific-Islander <input type="checkbox"/> Other Please Specify: _____		
Do you receive DPH Prevention or Ryan White Part B funding? <input type="checkbox"/> Yes or <input type="checkbox"/> No If not, what funding do you receive? <input type="checkbox"/> Part A Hartford <input type="checkbox"/> Part A NH/FF <input type="checkbox"/> Part C <input type="checkbox"/> Part D <input type="checkbox"/> Other: Please Specify _____			
Type of Training: <input type="checkbox"/> Pre-Requisite Training Required for all NEW HIV Care & Prevention Providers ** Time in your current position ____Days____Months CORE (Check only one) Use a separate form for additional trainings. <input type="checkbox"/> Medical Case Manager <input type="checkbox"/> HIV Prevention Counselor <input type="checkbox"/> CRCS Provider <input type="checkbox"/> HIV Educator <input type="checkbox"/> Drug Treatment Advocate (DTA) <input type="checkbox"/> Continuing Education Workshop (CE) For participants who currently hold a certificate of training : Name of Training: _____			
Agency: _____			
Address:			
City: _____		State: _____	Zip _____
Telephone #: _____		Fax #: _____	
E-mail address: _____		Other Email: _____	
Supervisor approved: Signature required			
Please tell us about your educational background: <input type="checkbox"/> less than 12 years of education <input type="checkbox"/> High School/GED <input type="checkbox"/> College _1_ _2_ _3_ _4_ _+ <input type="checkbox"/> Graduate degree (MA, MPH, MS, etc)			
Experience working in the HIV/AIDS field _____ Months _____ Years			
What are your expectations for this training? 			

DPH Use Only
Received on: _____ <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved