

NIRS Trainee Form – FY 2017

For use by LENDs and UCEDDs

*Response Required

MAIN RECORD

ID Number: _____

*First Name _____ Middle _____ *Last Name _____

Former Name: _____

*Academic Degree/Credential Achieved: _____

Current Address

*Address Line 1: _____

Address Line 2: _____

*City: _____ *State: _____

County of Origin: out of state unknown

*Zip/Postal Code: _____

(Because students often move to a location near the school they will be attending, we strongly recommend asking trainees to provide the name of the county they relocated from to attend school, rather than their current county of residence.)

Primary Email: _____

Secondary Email: _____

Phone: (_____) _____ - _____

Permanent Address

Name of Permanent Contact: _____

Relationship of Permanent Contact: _____

*Address Line 1: _____

Address Line 2: _____

*City: _____ *State: _____

*Zip/Postal Code: _____

Phone: (_____) _____ - _____

Date of Birth: ____ / ____ / ____

*Gender: M F

Beginning with Fy06 version of NIRS, race and ethnicity information is collected in a manner consistent with the US Census categories. Please provide both race and ethnicity information.

*** Race** (check one):

- White** refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Black or African American** refers to people having origins in any of the Black racial groups of Africa.
- American Indian and Alaskan Native** refer to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
Tribe: _____
- Asian** refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g. Asian Indian).
- Native Hawaiian and Other Pacific Islander** refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- More than one race** includes individuals who identify with two or more racial designations.
- Unrecorded** is included for individuals who are unable to identify with the categories.

***Ethnicity** (check one):

Hispanic is an ethnic category for people whose origins are in the Spanish-speaking countries of Latin America or who identify with a Spanish-speaking culture. Individuals who are Hispanic may be of any race.

- Hispanic
- Non-Hispanic
- Unrecorded

***Primary Language**

Do you speak a language other than English at home?

- Yes, Spanish
- Yes, another language, please identify:
- No

If yes how well do you speak English?

- Very well
- Well
- Not well
- Not at all

***Position Setting at Admission:** _____

***Position Title at Admission:** _____

***Personal relationship with Disabilities:**

Is the trainee a ... (Check all that apply)

- Person with a disability
- Person with a special health care need
- Parent of a person with a disability
- Parent of a person with a special health care need
- Family member of a person with a disability
- Family member of a person with a special health care need
- None
- Unrecorded

TRAINEE YEAR RECORD

*Fiscal Year: **2017**

*Academic Level (Current enrollment status, not highest degree earned)

- Non Degree
- Undergraduate
- Masters
- Doctoral
- Post Doctoral
- Other

*Degree Program (provide appropriate abbreviation, e.g BA, MA, PhD, DDS,PharmD,etc.) _____

Position in Program (fellow, resident, intern, grad student, etc): _____

*Discipline: (Check one)

- | | |
|--|---|
| <input type="radio"/> Audiology | <input type="radio"/> Medicine-Pediatric Pulmonology |
| <input type="radio"/> Biological Sciences | <input type="radio"/> Medicine: General |
| <input type="radio"/> Dentistry-Pediatric | <input type="radio"/> Medicine: Pediatric |
| <input type="radio"/> Dentistry-Other | <input type="radio"/> Mental and Behavioral Health |
| <input type="radio"/> Disability Studies | <input type="radio"/> Nursing |
| <input type="radio"/> Education/Special Education | <input type="radio"/> Nursing-Family/Pediatric Nurse Practitioner |
| <input type="radio"/> Education: Administration | <input type="radio"/> Nursing-Midwife |
| <input type="radio"/> Education: Early Intervention/Early Childhood | <input type="radio"/> Nursing-Other |
| <input type="radio"/> Education: General Education | <input type="radio"/> Nutrition |
| <input type="radio"/> Epidemiology | <input type="radio"/> Occupational Therapy |
| <input type="radio"/> Family Studies | <input type="radio"/> Pastoral |
| <input type="radio"/> Family/Parent/Youth Advocacy | <input type="radio"/> Pharmacy |
| <input type="radio"/> Genetics/Genetics Counseling | <input type="radio"/> Physical Therapy |
| <input type="radio"/> Gerontology | <input type="radio"/> Psychiatry |
| <input type="radio"/> Health Administration | <input type="radio"/> Psychology |
| <input type="radio"/> Human Development/Child Development | <input type="radio"/> Public Administration |
| <input type="radio"/> Interdisciplinary | <input type="radio"/> Public Health |
| <input type="radio"/> Law | <input type="radio"/> Rehabilitation |
| <input type="radio"/> Liberal Arts & Sciences, Humanities, & General Studies | <input type="radio"/> Respiratory Therapy |
| <input type="radio"/> Medicine-Adolescent Medicine | <input type="radio"/> Social Work |
| <input type="radio"/> Medicine-Developmental-Behavioral Pediatrics | <input type="radio"/> Speech-Language Pathology |
| <input type="radio"/> Medicine-Neurodevelopmental Disabilities | <input type="radio"/> Other - Please specify:_____ |

*Current Contact Hours: (for current reporting period only--Must be 9 or more) _____

*Enrollment Status: (Check one)

- Full-Time Student
- Part-Time Student

*Year Start Date: ____ / ____ / ____ (Pertains to training program only, not academic program)

*Year Completion Date: ____ / ____ / ____ (Pertains to training program only; if the completion date for this year is currently unknown, supply an estimate and update with exact date once known)

*Trainee Type (note—these questions will be used to query trainees for Progress Report, Performance Measures and similar functions. If you will report a trainee as both a LEND and UCEDD trainee, answer Yes to both questions.)

*Is this a LEND Trainee? Yes No

*Is this a UCEDD Preservice Prep or Continuing Education Trainee? Yes No

***Does the LEND trainee have MCH support?** Yes No

***Upon completing their training, will the trainee qualify as a:** (Check one)

- Long-Term Trainee? (300+ hours upon completion of training)
- Intermediate Trainee? (40-299 hours upon completion of training)

Individuals whose entire training program is less than 40 hours may be captured in the Short Term Trainee “mini” dataset. Demographic information on the number of individuals trained through Short-term or Community Training programs is captured in the Activities dataset.

***If trainee has MCH support (“Yes” above), list MCH support (i.e., stipend and/or covered tuition/fees) for trainee:**

| | |
|----------------|-----------------|
| Stipend | \$ _____ |
| Tuition & Fees | \$ _____ |
| Total | \$ _____ |

***Support Type**

Check all categories to describe any program-related financial support that the trainee is currently receiving. (check all that apply)

Core Grant Funding

- MCH Core
- MCH Autism Supplement
- AIDD
- OSEP

Other Funding

- Clinical Fees
- Academic Department
- Internship
- Fellowship/Scholarship
- Other

None/Not Applicable

Product(s) Produced by the Student this year (Required if applicable)

(Must complete Product entry form for each new product.)

Presentation(s) by the Student this year:

Presentation Name: _____

Date: _____ Venue: _____

OPTIONAL:

Type of Participation: (Check all that apply)

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Didactic | <input type="checkbox"/> Practicum/Field Work |
| <input type="checkbox"/> Clinical | <input type="checkbox"/> Other – Please Specify: _____ |
| <input type="checkbox"/> Research | |

Which of the following training curricula is the trainee completing (independent of trainee’s funding source/s)?
(Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> MCH LEND | <input type="checkbox"/> Other – Please Specify: _____ |
| <input type="checkbox"/> ADD | |
| <input type="checkbox"/> OSEP | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Pediatric Residency | |