



### Montana Geriatric Education Center

32 Campus Drive • The University of Montana • Missoula, MT 59812-1522

Toll Free (866) 506-8432 • Local (406) 243-2453

Web: <http://mtgec.umontana.edu> • email: [montanagec@umontana.edu](mailto:montanagec@umontana.edu)

Thank you for your interest in the MTGEC Online Geriatric Education and Certificate Program. The program is presented online through The University of Montana's online course platform called Moodle (Option 1). If an individual does not have easy access to the internet or does not have an email address, a paper option can be selected. (Option 2).

The modules may be completed for personal use or to satisfy professional continuing education requirements. For the latter, appropriate professional organizations and state licensing boards have approved the modules. The cost for the program is based on the type of certification you request. Our general continuing education fee is \$50.00 and our professional continuing education fee is \$75.00. This fee covers all modules/materials for the program for one year.

To register for the program, the attached form must be completed and submitted to our office. There are two parts to this form: The first part will be used to initiate the process for access to the materials (either online or by mail). The second part asks for information that we are required to provide to our funding agency, HRSA. We appreciate all fields being filled in as completely as possible.

After your registration form and payment are received, you will be contacted within a week regarding your access to the materials. If you choose Option 1 for access (recommended), you will receive an email from us with your user name, password, and instructions on accessing the program. If you chose Option 2, MTGEC will contact you via phone to give further guidance.

To Pay By Check or credit card via mail:      Print the completed registration form below and mail along with your payment to:  
*Montana Geriatric Education Center  
The University of Montana  
32 Campus Dr., Skaggs Building #319  
Missoula, MT 59812-1522*

To Pay By Credit Card via Fax:                      Complete and print the registration form below and fax to  
(406) 243-4353

To Pay By Credit Card via email:                      Attach the completed form and e-mail to:  
[montana.gec@umontana.edu](mailto:montana.gec@umontana.edu)

If you have any further questions, please contact MTGEC at the following:  
(406) 243-2453 OR [montana.gec@umontana.edu](mailto:montana.gec@umontana.edu)



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**Continuing Education Program Registration Form**

First and Last \_\_\_\_\_

Mailing Address \_\_\_\_\_

(Please check one: This is a  Home Address  Work Address)

Daytime Telephone Number \_\_\_\_\_

Email Address (required) \_\_\_\_\_

Discipline or Profession \_\_\_\_\_

Business or Organization \_\_\_\_\_

**ACCESS TYPE (select one)**

Access Type 1: Moodle Online Annual Access .....

Access Type 2: Paper .....

**CONTINUING EDUCATION CREDIT OPTIONS (select one)**

Option 1: MTGEC General Continuing Education Certificate. **Cost: \$50.00**.....

Option 2: MTGEC Professional Continuing Education Certificate. **Cost \$75.00**  
*Appropriate professional organizations and state licensing boards have approved the modules for continuing education credit.* .....

**What type of professional continuing education credits/certification do you want? (i.e. RN, PT, OT, SW)\_\_\_\_\_**

**PAYMENT METHOD**

**Total Due: \$50  or \$75**  (select one based on your selection above)

Check Number (payable to "The University of Montana") \_\_\_\_\_

Credit Card Type Visa  Master Card

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Security Code \_\_\_\_\_

Signature \_\_\_\_\_

**CONTACT INFORMATION**

MTGEC  
32 Campus Drive SB 319  
59812-1522

Fax: 406-243-4353  
Telephone: 406-243-2453 or Toll Free: 866-506-8432 Missoula MT  
Email: [montana.gec@umontana.edu](mailto:montana.gec@umontana.edu)

# MTGEC Participant Profile

Thank you for registering for the program. Please take a few minutes to complete this profile. We request your information to help us secure continued funding. Participant Profile information is crucial for our reports to the Federal Bureau of Health Professions, a major funding agency for geriatric-related education programs.

**The information provided is kept strictly confidential.**

## BIO-DEMOGRAPHIC INFORMATION:

Gender:  Female  Male

Birth Year \_\_\_\_\_

What is your age group?  Less than 20 yrs.  20-29 yrs.  30-39 yrs.  40-49 yrs.  50-59 yrs.  60 or older

What is your ethnicity? (Please check all that apply.)

American Indian or Alaska Native

White

Asian, specify \_\_\_\_\_

Black/African American

Native Hawaiian/Other Pacific Islander

Other, specify \_\_\_\_\_

Are you Hispanic-Latina/Latino?  Yes  No

Are you retired?  Yes  No

Are you a National Health  Yes  No

Service Corps member? (ie. GCNS-BC or GNP-BC)

## EDUCATION BACKGROUND:

What is your most advanced degree? (Specify degree)

Elementary/secondary school \_\_\_\_\_

Associates Degree (e.g., AA, AAS) \_\_\_\_\_

Diploma (e.g., RN) \_\_\_\_\_

Baccalaureate Degree (e.g., BA) \_\_\_\_\_

Masters Degree (e.g., MA, MS) \_\_\_\_\_

Doctorate (e.g., PhD, EdD) \_\_\_\_\_

MD  DO  Other, specify \_\_\_\_\_

Do you have an additional certificate in geriatrics? (ie. CAQ - Certificate of Added Qualifications in Geriatrics or a Board Certification in Gerontology)  Yes  No

## SPECIFIC PROFESSIONAL DISCIPLINE:

### **Check Only One**

#### Primary Care Disciplines

##### **Allopathic Medicine**

Family Medicine

Internal Medicine

Psychiatry

Other Medicine \_\_\_\_\_

##### **Osteopathic Medicine (DO)**

Family Medicine

Internal Medicine

Psychiatry

Other Medicine \_\_\_\_\_

##### **Nursing**

LPN  RN and/or BSN

NP  CNS

Other, Specify \_\_\_\_\_

Pharmacist

##### **Other**

Physician Assistant  Podiatry

Chiropractic  Dentistry

Other, specify \_\_\_\_\_

#### Allied Health Disciplines

Clinical Laboratory Sciences

Dental (Hygienist, Assistants)

EMT

Health Information  
(Administrators, Technicians)

Home Health Aide/ Medical Assistant

Nutrition and Food Services

Preventive Medicine

Rehabilitation (Therapists or Assistants  
in OT, PT, or Speech/Audiology)

Technician: \_\_\_\_\_

Other, Allied Health \_\_\_\_\_

#### Related Professions

Gerontology

Clinical Psychology/Counseling

Other Counseling

Health Administration

Nursing Home Administration

Health Education

Law (Attorney, Paralegal)

Law Enforcement/Security

Protective Services

Pastoral Care

Public Health

Dental Public Health

Recreational Therapies

Social/Behavioral Sciences

Social Work

Other, specify \_\_\_\_\_

# MTGEC Participant Profile *(continued)*

**What is Your Primary Role: (Check one)**

- Administrator/Manager
- Academic Faculty
- Clinical Faculty
- Health Care Practitioner (anyone who shares responsibility for direct delivery of health care or related services)
- Other, specify \_\_\_\_\_
- Fellow
- In Service/Continuing Education Coordinator
- Resident

**IF YOU ARE A DIRECT CARE PROVIDER please answer the following:**

**Do you spend at least 50% of your time in any of the following sites that serve underserved populations?**

Check all that apply:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Community Health Center</li> <li><input type="checkbox"/> Migrant Health Center</li> <li><input type="checkbox"/> Mental Health Center</li> <li><input type="checkbox"/> Federally Qualified Health Center</li> <li><input type="checkbox"/> Health Care for Homeless</li> <li><input type="checkbox"/> Dental Care in HPSA site</li> <li><input type="checkbox"/> Primary Care, Health Professional Shortage Area (HPSA)</li> <li><input type="checkbox"/> Other _____</li> <li><input type="checkbox"/> Check here if none are applicable to your practice.</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Rural Health Center</li> <li><input type="checkbox"/> Indian Health Center</li> <li><input type="checkbox"/> State/Local Health Department</li> <li><input type="checkbox"/> State Designated Ambulatory Area</li> <li><input type="checkbox"/> Public Housing Primary Care</li> <li><input type="checkbox"/> Governor Designated Area</li> </ul> |
|--|---|

**Please indicate the clinical sites in which you work (Check all that apply). For each location you check, please indicate the number of patient encounters you have in an average day.**

- Check here if you do not have regular therapeutic contact with patients.
- |   |  |
|---|--|
| <p style="text-align: center;">(# of patients)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Ambulatory Care Centers _____</li> <li><input type="checkbox"/> Assisted Living _____</li> <li><input type="checkbox"/> Chronic &amp; Acute Hospitals _____</li> <li><input type="checkbox"/> Home Care _____</li> <li><input type="checkbox"/> Hospice _____</li> <li><input type="checkbox"/> Other, describe _____</li> </ul> | <p style="text-align: center;">(# of patients)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nursing Homes _____</li> <li><input type="checkbox"/> Palliative Care _____</li> <li><input type="checkbox"/> Senior Centers _____</li> <li><input type="checkbox"/> Senior Housing _____</li> <li><input type="checkbox"/> Telehealth _____</li> </ul> |
|---|--|

**Approximately what percentage of the adults over age 65 that you serve:**

**1. Has Medicaid, Medicare, Indian Health Service or is Uninsured?**

Medicaid \_\_\_\_%                      Medicare \_\_\_\_%                      IHS \_\_\_\_%                      Uninsured \_\_\_\_%

**2. Is one of the following ethnicities?**

Black African American \_\_\_\_%                      Asian \_\_\_\_%                      Caucasian or White \_\_\_\_%                      Mixed \_\_\_\_%