



MTGEC PARTICIPANT PROFILE
A Comprehensive Approach to Late Life Depression
Tuesday, October 11, 2011

Thank you for registering for the program. Please take a few minutes to complete this profile. We request your information for two reasons: 1) To help us secure continued funding. Participant profile information is crucial for our reports to the U.S. Bureau of Health Professions, a major funding agency for geriatric-related education programs. 2) To include you in our database for information regarding future programming.

The information provided is kept strictly confidential.
THANK YOU.

Name: Ms. Mrs. Mr. Dr. _____

Credentials: (e.g. RN, PT, MD) _____

Position: _____

Organization: _____

Mailing Address: _____

Telephone: _____

E-Mail: _____

Gender: Female Male **Birth Year** _____

What is your age group?

- Less than 20 yrs. 30-39 yrs. 50-59 yrs.
 20-29 yrs. 40-49 yrs. 60 or older

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

- American Indian or Alaska Native White
 Asian, specify _____ Black/African American
 Other, specify _____ Native Hawaiian/
Other Pacific Islander

Are you Hispanic-Latina/Latino? Yes No

Are you retired? Yes No

**Are you a National Health Service
Corps member?** Yes No

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? This would include a CAQ (Certificate of Added Qualifications) in Geriatrics or a Board Certification in Gerontology (GCNS-BC or GNP-BC) Yes No

IF YOU ARE A DIRECT CARE PROVIDER:

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

Check here if none are applicable to your practice.

Check all that apply:

- Community Health Center Rural Health Center
 Migrant Health Center Indian Health Center
 Mental Health Center State/Local Health Dept.
 Federally Qualified Health Center State Designated Ambulatory Area
 Health Care for Homeless Public Housing Primary Care
 Dental Care in HPSA site Governor Designated Area
 Primary Care, Health Professional Shortage Area (HPSA)
 Other _____

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 _____%

What is your profession? (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
- Physician Assistant Podiatry
- Chiropractic Dentistry

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 _____

Primary Role: (Check one)

- Administrator/Manager
- Clinical Faculty
- In Service/Continuing Education Coordinator
- Other, specify _____
- Academic Faculty
- Health Care Practitioner (anyone in a field related to health care who shares responsibility for delivery of health care or related services)
- Student, specify _____
- Resident
- Fellow
- Other, specify _____

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.

- | | |
|--|--|
| (# of patients) | (# of patients) |
| <input type="checkbox"/> Ambulatory Care Centers _____ | <input type="checkbox"/> Nursing Homes _____ |
| <input type="checkbox"/> Assisted Living _____ | <input type="checkbox"/> Palliative Care _____ |
| <input type="checkbox"/> Chronic & Acute Hospitals _____ | <input type="checkbox"/> Senior Centers _____ |
| <input type="checkbox"/> Home Care _____ | <input type="checkbox"/> Senior Housing _____ |
| <input type="checkbox"/> Hospice _____ | <input type="checkbox"/> Telehealth _____ |
| <input type="checkbox"/> Other, describe _____ | |