

STAFF INFORMATION FORM

Please provide all requested information and answer all fields

Agency: _____ Date: / /
 First Name: _____ Last: _____ MI: _____
 State Counselor ID: _____ SSN: _____ Honorable (Mrs., Dr., etc.): _____
 Phone: _____ Email: _____ Fax: _____
optional

FUNCTIONAL RESPONSIBILITY (check only one)

- HCT Counselor
- Administrator
- Data Entry Clerk

STATUS (check any that apply)

- Active Staff
- Key Staff
- Volunteer

GENDER (check only one)

- Male
- Transgender (Male to Female)
- Don't Know
- Female
- Transgender (Female-to-Male)
- Other (specify): _____

ETHNICITY (indicate the primary racial identity with a "1," any secondary racial identity with a "2," and any tertiary racial identity with a "3")

- White (Not Hispanic)
- African American (Not Hispanic)
- American Indian/Alaskan Native
- Hispanic/Latino(a)
- Asian/Pacific Islander
- Other (specify): _____

EDUCATION (check all that apply)...

- BA
- BS
- BSN
- CPA
- DDS
- MA
- MBA
- MD
- MDS
- MPH
- MS
- MSW
- PhD
- PsyD
- RN
- GED / High School Diploma
- None / NA
- Other: _____

DO YOU PERSONALLY PERFORM HIV COUNSELING & TESTING? Yes No

SITES (List sites at which the HIV Counselor provides services)

Site: _____
 Site: _____
 Site: _____

COUNSELING QUALIFICATIONS (Check one box and provide all requested dates [MM/DD/YYYY]).

- Does **Not** Perform Counseling
 - Performs Non-Rapid Counseling **Only**
 - Performs Non-Rapid **and** Rapid Test Counseling
- BASIC 1 Completion Date: / /
 BASIC 2 Completion Date: / /
 CET (State) Completion Date: / /

RAPID TEST KIT QUALIFICATIONS (Check one box and provide all requested dates [MM/DD/YYYY]).

- Does **Not** Perform Rapid Tests
 - Performs** Rapid Tests
- Test Kit Training Date: / /
 Initial CAT Date: / /
 Six-Month CAT Date: / /
 Last CAT Date: / /
 Next CAT Date: / /
 CAT: Competency Assessment Testing

PHLEBOTOMY QUALIFICATIONS (Check one box and provide all requested dates [MM/DD/YYYY]).

- Does **Not** Perform Phlebotomy
 - Completed **Limited** Phlebotomist Certificate
 - Completed **Certified** Phlebotomist Certificate
 - Qualified by Virtue of **License** (RN, e.g.)
- Certification Date: / /
 Last PCT Date: / /
 Next PCT Due: / /
 PCT: Phlebotomy Competency Testing

Please fax this form to your OAPP Program Manager
 Fax: (213) 351-7698