

**Clinician Scholars Program
APPLICATION**

Date: _____

Name: _____ Credentials: _____

Employer: _____

Work title: _____

Preferred Mailing Address

City _____ State _____ Zip Code _____

Additional Contact Information

Phone: _____ Fax: _____

E-mail: _____ Cell Phone: _____

Preferred Method of Correspondence?

Electronic/E-mail Fax

Preferred Method of Contact?

E-mail Phone Cell Phone Pager

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0281, and the expiration date is 5/31/2010. Public reporting burden for this collection of information is estimated to average .21 hours per respondent annually, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857.

PIF

HRSA AIDS Education and Training Centers PARTICIPANT INFORMATION FORM

Please completely fill in the circles (●) when answering the questions below.

1. To create your unique ID number, use the month of your birth, day of your birth, and last four digits of your SSN. For example, May 29, 123-345-6789, has the ID number 05296789.

M	M	D	D	#	#	#	#
Birth				Last 4 SSN			

Unique ID Number

2. Today's Date (mm/dd/yy)

		/			/		
mm			dd			yy	

3. Your Primary Profession/Discipline (Select one)

- | | |
|---|---|
| <input type="radio"/> Dentist | <input type="radio"/> Clergy/Faith-Based Professional |
| <input type="radio"/> Other Dental Professional | <input type="radio"/> Dietitian/Nutritionist |
| <input type="radio"/> Nurse Practitioner | <input type="radio"/> Health Educator |
| <input type="radio"/> Other Advanced Practice Nurse | <input type="radio"/> Mental Health Professional |
| <input type="radio"/> Nurse | <input type="radio"/> Public Health Professional |
| <input type="radio"/> Pharmacist | <input type="radio"/> Social Worker |
| <input type="radio"/> Physician | <input type="radio"/> Substance Abuse Professional |
| <input type="radio"/> Physician Assistant | <input type="radio"/> Other (specify): _____ |

4. Your Primary Functional Role (Select one)

- | | |
|---|--|
| <input type="radio"/> Administrator | <input type="radio"/> Intern/Resident |
| <input type="radio"/> Agency Board Member | <input type="radio"/> Researcher/Evaluator |
| <input type="radio"/> Care Provider/Clinician | <input type="radio"/> Student/Graduate Student |
| <input type="radio"/> Case Manager | <input type="radio"/> Teacher/Faculty |
| <input type="radio"/> Client/Patient Educator | <input type="radio"/> Other (specify): _____ |

5. Your Principal Employment Setting (Select one)

- | | |
|---|---|
| Clinic | Other Settings |
| <input type="radio"/> Academic Health Center | <input type="radio"/> College/University |
| <input type="radio"/> Community Health Center | <input type="radio"/> Community-Based Organization |
| <input type="radio"/> Family Planning | <input type="radio"/> Correctional Facility |
| <input type="radio"/> HIV Clinic | <input type="radio"/> HMO/Managed Care Organization |
| <input type="radio"/> Hospital-Based Clinic | <input type="radio"/> Hospital/ ER |
| <input type="radio"/> Indian Health Services/Tribal | <input type="radio"/> Military/VA |
| <input type="radio"/> Infectious Disease | <input type="radio"/> Private Practice |
| <input type="radio"/> Maternal/Child Health | <input type="radio"/> State/Local Health Department |
| <input type="radio"/> Mental Health | <input type="radio"/> Non-Health |
| <input type="radio"/> Rural Health | <input type="radio"/> Other Primary Care |
| <input type="radio"/> Sexually Transmitted Disease | <input type="radio"/> Not Working (skip to item 9) |
| <input type="radio"/> Substance Abuse | |

6. Primary Employment Setting/Zip code

- a. Rural Suburban Urban

b.

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Zip code

7. Is the employment setting a faith-based organization?

- Yes No Don't Know

8. Does the employment setting receive Ryan White Program funding?

- Yes No Don't Know

If you don't know, please write the full name of your employer:

9. Are you of Hispanic, Latino/a, or Spanish origin?

- Yes No

10. Your Racial Background (Select all that apply):

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

11. Your Gender:

- Female Male Transgender

12. Do you provide services directly to clients/patients?

- Yes No [Stop here. You are done with this form.]

13. Do you provide services directly to HIV-infected clients/patients?

- Yes No/Don't Know [Stop here. Go to PIF Page 2.]

14. How many years have you been providing services directly to HIV-infected clients/patients? [Round up to the nearest whole year.]

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15. Estimate the NUMBER of HIV-infected clients/patients to whom you provide direct services in an average MONTH.

- None [Stop here. You are done with this form.]
 1-9 10-19 20-49 50+

For questions 16-18, estimate the PERCENTAGE of your HIV-infected clients/patients in the past YEAR who were:

16. Racial or Ethnic Minorities

- None 1-24% 25-49% 50-74% ≥75%

17. On Antiretroviral Therapy

- None 1-24% 25-49% 50-74% ≥75%

18. Women

- None 1-24% 25-49% 50-74% ≥75%

For Office Use Only	May 2007	<table border="1"><tr><td></td><td></td></tr></table> AETC			<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> Sub-site					<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> Program ID									<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table> Agency					Ryan White Program <input type="radio"/> Yes <input type="radio"/> No

Please completely fill in the circles (●) when answering the questions below.

Please complete this section only if you answered “Yes” to question 12 above.

Please copy your Unique ID from the first page

M	M	D	D	#	#	#	#
<i>Birth</i>				<i>Last 4 SSN</i>			
Unique ID Number							

19. Do you test/screen patients for HIV/AIDS in your practice setting?

- Yes No

20. Which statement best describes how you most often provide services to HIV/AIDS patients (select one)?

- I have not had any HIV+ patients in my practice.
- I provide only non-medical services to HIV+ patients.
- I provide only consulting services to HIV+ patients.
- I refer/transfer HIV+ patients for all medical care.
- I provide primary care, refer/transfer HIV+ patients for HIV Treatment only.
- I provide all HIV treatment, refer/transfer HIV+ patients for non-HIV primary care.
- I provide all medical care, refer/transfer HIV+ patients when antiretroviral treatment fails.
- I provide all medical care throughout the course of the disease.

For Office Use Only	May 2007	<input type="text"/> AETC	<input type="text"/> Sub-site	<input type="text"/> Program ID
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Please respond to the following statements:

I currently provide direct clinical care services and anticipate continuing to do so within the Midwest region served by <i>MATEC: Illinois, Indiana, Iowa, Michigan, Missouri, Minnesota, and Wisconsin.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know
I currently provide direct clinical care to <i>racial and ethnic minorities.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know
I currently provide direct clinical care to <i>medically underserved</i> populations.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know
I currently provide direct clinical care to <i>incarcerated</i> populations.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know
I currently provide direct clinical care at a clinic <i>funded by the Ryan White Program.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know
I currently provide direct clinical care at a <i>rural and/or Community Health Center.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know
I currently provide direct clinical care at a <i>federally-supported health care facility</i> (e.g. Indian Health Service, Veterans Administration, etc.).	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know
I currently prescribe antiretroviral medications to patients that are paid for by my state's <i>AIDS Drug Assistance Program (ADAP).</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I Don't Know

On a typical day - How many hours do you spend at work? _____

On a typical day - Please estimate the number of work hours that you spend in these roles:

Administrative Duties

Zero 1-2 hours 2-4 hours 3-4 hours ≥ 5 hours

Research

Zero 1-2 hours 2-4 hours 3-4 hours ≥ 5 hours

Teaching

Zero 1-2 hours 2-4 hours 3-4 hours ≥ 5 hours

Direct Patient Care

Zero 1-2 hours 2-4 hours 3-4 hours ≥ 5 hours

Do you anticipate any significant changes in your job responsibilities in the next 6 months?

Yes No

If you answered yes, please explain _____

Do you anticipate any significant changes in your employment setting in the next 6 months?

Yes No

If you answered yes, please explain _____

Please answer this section if you are a Nurse, NP or APN:

Are you certified as an AIDS Certified Registered Nurse (ACRN)?

Yes No

If No:

Do you plan to become ACRN certified?

Yes No Do Not Know

Is your application to this program in part for preparation for the certification examination?

Yes No Do Not Know

Are you certified as an Advanced AIDS Certified Registered Nurse (AACRN)?

Yes No

If No:

Do you plan to become AACRN certified?

Yes No Do Not Know

Is your application to this program in part for preparation for the certification examination?

Yes No Do Not Know

Please answer this section if you are an MD, DO, PA, NP or Pharmacist:

Are you certified by the American Academy of HIV Medicine as an HIV Specialist?

Yes No

If No:

Do you plan to become certified as an HIV Specialist?

Yes No Do not know

Is your application to this program in part for preparation for the certification examination?

Yes No Do not know

The remainder of the application should be answered by all applicants

In this next section, we would like to know more about your training/educational experiences (CE, CME, non CME, formal course work, etc.) and your level of interest or perceived need for additional training on the topics below.

Instructions:

Step 1 *If you have received training on the topic – select “Yes”*
*If you have **not** received training on the topic – select “No”*

Step 2 *Circle the number in the right column that best corresponds to your level of need for additional training on this topic.*



	Yes	No	Low	Need	High		
Local, National and International HIV Epidemiology	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
CDC HIV Testing Recommendations	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
HIV Testing (including Rapid Testing)	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Initiation of Antiretroviral Therapy	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Selecting an Antiretroviral Regimen	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Preferred Antiretroviral Regimens	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Common Side Effects and Drug Interactions of Antiretrovirals	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Managing Special Populations (Pregnant Women, Co Infected with Hepatitis, TB or Others)	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Standards of Care for Patients with HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Guidelines for the Management of HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Coordinating the Care of Patients with HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Sources for Current Resources (DHHS Guidelines, IAS Recommendations)	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Utilizing Laboratory Findings, Patient History and Patient Readiness Assessment to Direct Treatment Plan	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5

	Yes	No	Low	Need	High		
Monitoring Response to Antiretroviral Therapy	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Recognizing and Managing Failure of Antiretroviral Therapy	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Uses for and Interpretation of Resistance Testing	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Utilizing Findings of Resistance Testing to Formulate New Antiretroviral Regimen	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Importance of Adherence	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Factors that Impact Adherence	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Patient Centered Techniques for Encouraging Adherence	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Prophylaxis Criteria and Treatment Options for Pneumocystis Pneumonia, TB and Mycobacterium Avium Intracellulare	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Common Presentations of Pneumocystis Pneumonia and Cryptococcal Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Initial Management of Fever and/or Abnormal Chest X ray in Patients with an Absolute CD4 Count of 100 or Less	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Appropriate Screening/Testing for HIV Associated Clinical Syndromes	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Formulate Clinical Interventions for HIV Associated Clinical Syndromes	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Formulate Clinical Interventions for Co Morbid Conditions Associated with HIV	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Sources for Current Resources on Common Drug Class Side Effects	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Managing Common Side Effects of Antiretrovirals	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Interactions between Antiretroviral Medications and Other Commonly Prescribed Drugs (Cholesterol, Psychotropic)	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Screening Tools, Methods and Resources for Managing Patients with Substance Use, Mental Health and/or Sexual Risk Behaviors.	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
CDC Recommendations for Incorporating Prevention into HIV Care	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Strategies for Reducing Sexual Risk and Drug Use Related Harm to Patients	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Attitudes and Biases that Impact Patient Care	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Impact of Mental Health, Substance Use, Homelessness, Poverty, Incarceration on HIV Care	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Strategies and Resources for Addressing Barriers to Care	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5
Other:	<input type="checkbox"/>	<input type="checkbox"/>	1	2	3	4	5

How did you hear about the MATEC Clinician Scholars Program?

Please attach Response

Briefly explain how you see the MATEC Clinician Scholars Program enhancing your skills, knowledge or attitudes about managing HIV-infected patients (Please limit your responses to 4 paragraphs or about 1 page):

Please attach Response

If accepted into the MATEC Clinician Scholars Program, what do you anticipate will be your 3 most important goals or areas of concentration?

1. _____

2. _____

3. _____

Do you anticipate using work hours to complete the requirements of this training program?

Yes No

*If you answered Yes, a **Statement of Workplace Endorsement** will need to accompany this application.*

Statement of Commitment

I understand that if I am accepted to the Scholars program:

- ◆ I am expected to complete at least 32 hours of study in 12 months as described by MATEC
- ◆ I may be required to participate in two regional trainings that may require overnight travel (reimbursed by MATEC)
- ◆ My training will be focused on 11 areas of HIV/AIDS capabilities and I will be assessed throughout the program to determine my progress toward these

Applicant Signature

Date

Submission Information

Congratulations! You have completed the application for the MATEC Clinician Scholars Program. This is the first step in your journey to becoming a MATEC Clinician Scholar.

In addition to the application, we invite Scholars to submit a **letter of reference** to support their application. This is not a requirement, but in the case of multiple applicants, letters of reference will be taken into consideration. We encourage you to select a reference who really knows your clinical capacity, either a current or recent supervisor or a colleague familiar with you as a team member. This person should know your work and be able to speak to your capacity to enhance the field of HIV practice in the future.

Also, if you plan to use work time to complete the requirements of this training must obtain a **statement of workplace endorsement** supporting your participation in the Scholars Program. The workplace endorsement is a statement that should be signed by your immediate supervisor. A supervisor signature helps MATEC know that you will be adequately supported in your efforts to complete the Clinician Scholars Program should you be accepted.

Templates for the Letter of Reference and the Workplace Endorsement have been provided as part of your application materials.

Please return the completed application and/or other documents to:

Midwest AIDS Training and Education Center
Attention: April Grudi, MPH, CHES
Phone: 317 948 6496
Fax: 317 944 2327
Email: agrudi@darian.org

Clinician Scholars Program

LETTER OF REFERENCE

MATEC invites Scholars to submit a **letter of reference** to support their application. This is not a requirement, but in the case of multiple applicants, letters of reference will be taken into consideration. We encourage you to select a reference who really knows your clinical capacity, either a current or recent supervisor or a colleague familiar with you as a team member. This person should know your work and be able to speak to your capacity to enhance the field of HIV practice in the future.

Letter of Reference

Date: _____

Your Name: _____

Your Primary Discipline:

- | | |
|--|---|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Advanced Practice Nurse |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Dentist/Dental Professional | <input type="checkbox"/> Other (please specify) _____ |

Name of Scholars Applicant: _____

Relationship to Applicant: _____

Length of time you have known applicant: _____

About Clinician Scholars Program

MATEC's Clinician Scholars Program or *Scholars Program* is designed for front line clinical care providers who are interested in expanding their capacity to provide HIV/AIDS care. Scholars can expect to receive 12 months of in-depth training related to the diagnosis, treatment, medical management, and prevention of HIV infection. *The Scholars Program* is intended to prepare clinicians to provide HIV/AIDS testing and care based on a set of standardized clinical capabilities, but is flexible enough to meet the individual needs of any clinical care provider.

Based on this program description, please tell us why you think that the applicant listed above is a good candidate for the Clinician Scholars Program. Include in your answer details of the applicant's work history and capabilities, as well as how you view the applicant's potential to be a leader in the HIV care workforce.

Signature: _____

Thank you very much for your time and consideration.

**Clinician Scholars Program
STATEMENT OF WORKPLACE ENDORSEMENT**

This statement is only required to be completed by applicants who anticipate using work hours to complete the requirements of this training program. The workplace endorsement is a statement that should be signed by your immediate supervisor. A supervisor signature helps MATEC know that you will be adequately supported in your efforts to complete the Clinician Scholars Program should you be accepted.

To be completed by the applicant

Name of the applicant:

Date:

Estimated number of hours needed to successfully complete the program:

Estimate how much work time you will need to use to successfully complete the program:

If you are not planning to use any work time to successfully complete the program, you do not need to have your direct supervisor complete the next section of this form.

Applicant's signature

To be completed by applicant's direct supervisor

Name:

Date:

Your relationship to applicant:

I have read the attached description of HIV Clinician Scholars Program and the respective Program Syllabus. I am aware that _____ (name of applicant) is applying for this program, and pending acceptance into the Scholars Program, is anticipating a start date of _____.

This application is supported by me and other relevant staff in our work setting. I believe that I can provide adequate flexibility and encouragement to my colleague as he/she participates in this training experience.

Signature of applicant's direct supervisor