



FAX BACK REGISTRATION FORM

Fax registration to 202-895-9484

DEADLINE: May 23, 2006

Please photocopy for additional registrants, if necessary

I am a (please check one):

Physician Nurse
 Nurse Practitioner Case Manager
 Nursing Home Admin. Social Worker
 Dentist Student Program/Major: _____
 Other: _____

.....
PLEASE PRINT LEGIBLY:

NAME _____
Print as you wish to be recorded on official documents with credentials

Organization/Affiliation _____

Position Title _____ Discipline _____

Street Address (check if home address / /) _____

City _____ State _____ Zip _____

Work Telephone _____ Fax _____ Email _____

Special Needs?: _____

We request that you provide the following information about yourself for our reporting purposes:

Please check your ethnicity:

African American Hispanic Asian Caucasian
 American Indian/Alaska Native Native Hawaiian/Pacific Islander _____ Other (specify)

Please check your age range: Under 20 20-29 30-39 40-49 50-59 60+

Do you work in an underserved area? Yes No

Please check the population you work with:

African American Hispanic Asian Caucasian
 American Indian/Alaska Native Native Hawaiian/Pacific Islander _____ Other (specify)

Approximately how many of your clients receive Medicare or Medicaid, or are uninsured (estimates):

Medicare	<input type="checkbox"/> 0-25 %	<input type="checkbox"/> 26-50%	<input type="checkbox"/> 51-75%	<input type="checkbox"/> 76-100%
Medicaid	<input type="checkbox"/> 0-25 %	<input type="checkbox"/> 26-50%	<input type="checkbox"/> 51-75%	<input type="checkbox"/> 76-100%
Uninsured	<input type="checkbox"/> 0-25 %	<input type="checkbox"/> 26-50%	<input type="checkbox"/> 51-75%	<input type="checkbox"/> 76-100%