





# FAX BACK REGISTRATION FORM

**Fax registration to 202-895-9484**

**DEADLINE: March 21, 2006**

**Please photocopy for additional registrants, if necessary**

**I am a (please check one):**

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

**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%