



OVAR/GEC PARTICIPANT INFORMATION

“Differential Diagnosis for Alzheimer’s Disease and Other Dementias”

Dr. William Markesbery, MD

Director, UK Sanders-Brown Center on Aging and UK Alzheimer’s Disease Center and Professor of Pathology and Neurology

Wednesday, March 29, 2006 from Noon – 1:00 pm
KY TeleHealth Network

The session is partially supported by funding through the USDHHS and HRSA. In order to continue to receive funding we are required to report as Group Data the following information about participants who attend GEC trainings. The information you provide is kept confidential. We sincerely appreciate your assistance in answering the questions below.

I plan to attend this program at the following facility: _____ City: _____

PLEASE PRINT

Last 4 digits of Social Security #: _____ Highest Degree/Credentials: _____

First Name: _____ MI: _____ Last Name: _____

Agency/Organization: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Counties of work: _____ EMAIL: _____

Work Phone: (____) _____ Work FAX: (____) _____

Gender: ♦ Male ♦ Female Month/Year of Birth: _____

Age: ♦ Under 20 ♦ 20-29 ♦ 30-39 ♦ 40-49 ♦ 50-59 ♦ 60-69 ♦ 70-79 ♦ 80+

Racial/Ethnic Background:

- ♦ American Indian or Alaska Native
- ♦ Black or African American
- ♦ Native Hawaiian/Other Pacific Islander
- ♦ White or Caucasian
- ♦ Asian (specify: _____ e.g. Asian Indian, Chinese, (Filipino, Japanese, Korean, Thai, etc.)
- ♦ Hispanic/Latino
- ♦ Other, Specify: _____

Do you consider yourself to have ever been from an economically or educationally disadvantaged background? ♦ Yes ♦ No

Professionally, do you serve a disadvantaged or underserved population or community? ♦ Yes ♦ No

OVAR/GEC staff will contact you for follow up on the use of training content and materials which helps us to improve trainings and the care for older adults. If this is not acceptable, check here ____ Do Not Contact Me.

If you are a **health care practitioner** and spend at **least 50% of your time** with underserved populations (e.g., low socioeconomic status, limited access to care, geographically isolated, etc.) please check below the type of your agency or institution:

Type of Agency: (please choose only one response)

- | | | |
|-------------------------------------|--|---------------------------------------|
| ◆ Not Applicable | ◆ Ambulatory Practice Sites
Designated by State Governors | ◆ Mental Health Center |
| ◆ Community Health Center | ◆ Migrant Health Center | ◆ Indian Health Service |
| ◆ Health Care for Homeless Center | ◆ HPSA (Federally Designated Health
Professionals Shortage Area | ◆ State or Local Health
Department |
| ◆ Rural Health Clinic | ◆ Public Housing Primary Care Center | ◆ Other,
Specify _____ |
| ◆ Federally Qualified Health Center | | ◆ Don't Know |

Discipline or Profession and Educational Background: Pick the **ONE category** out of the three that best describes your discipline/profession and **check only ONE response** under that category).

Primary Care Disciplines:

- ◆ Dentistry
- ◆ Family Medicine
- ◆ General Internal Medicine
- ◆ Nurse Practitioner
- ◆ Physician Assistant
- ◆ Other, Specify _____

Health Disciplines:

- ◆ Clinical/Counseling Psychology
- ◆ Counseling
- ◆ Health Administration
- ◆ Health Ministry
- ◆ Medicine: _____
- ◆ Other Advanced Practice Nurse (MSN)
- ◆ Parish Nurse
- ◆ Pastoral Care
- ◆ Public Health
- ◆ Pharmacy
- ◆ Social Work
- ◆ Undergraduate Nurse (RN/Diploma, BSN, LPN)
- ◆ Other, specify: _____

**Allied Health Disciplines/
Other:**

- ◆ Assistants (CNAs, STNAs, Home Health Aides, Medical Assistants)
- ◆ County Extension Agent
- ◆ Food & Nutrition Services (DIT or Technicians)
- ◆ Gerontology
- ◆ Health Information (Med. Records/Transcription)
- ◆ Other Technicians (EEG, EKG, EMT)
- ◆ Rehabilitation (Therapist or assistant in OT, PT, Recreation /Activities, Speech/Audio)
- ◆ Other, specify _____

Employment Information (What is Your Primary Role?) (Check one)

- | | |
|--|--|
| ◆ Administrator/Manager | ◆ Health Care Practitioner (anyone in a field related to health care or social services who shares responsibility for delivery of health care or related services) |
| ◆ Academic Faculty | ◆ Student (includes medical residents and fellows) |
| ◆ Clinical Faculty | |
| ◆ Inservice/Continuing Education Coordinator | |

Thank you for your time & assistance.

Please return your completed form to:
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Lexington, KY 40506-0442
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