



STAFF INFORMATION FORM

Please provide all requested information and answer all fields

Agency: _____ Date: _____

First Name: _____ Last: _____ M.I.: _____

State Counselor ID: _____ SSN: _____ Honorific (Mrs., Dr., etc.): _____

Phone: _____ Email: _____ Fax: _____ Cell: _____ optional

FUNCTIONAL RESPONSIBILITY *(check only one)*

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> HCT Counselor | <input type="checkbox"/> Management Staff | <input type="checkbox"/> Medical Director | <input type="checkbox"/> Executive Director |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Program Manager | <input type="checkbox"/> Chief Executive Officer | <input type="checkbox"/> President |
| <input type="checkbox"/> Data Entry Clerk | <input type="checkbox"/> Program Director | <input type="checkbox"/> Chief Financial Officer | <input type="checkbox"/> Chairperson of the Board |
| | | <input type="checkbox"/> Chief Operational Officer | <input type="checkbox"/> Board Member |

STATUS *(check any that apply)*

- | | | |
|---------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Active Staff | <input type="checkbox"/> Key Staff | <input type="checkbox"/> Contract Signature Authority |
| <input type="checkbox"/> Volunteer | <input type="checkbox"/> Certified | |

GENDER *(check only one)*

- | | | |
|---------------------------------|---|---|
| <input type="checkbox"/> Male | <input type="checkbox"/> Transgender (Male to Female) | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Female | <input type="checkbox"/> Transgender (Female-to-Male) | <input type="checkbox"/> Other <i>(specify)</i> : _____ |

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

- | | | |
|---|--|---|
| <input type="checkbox"/> White (Not Hispanic) | <input type="checkbox"/> African American (Not Hispanic) | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Hispanic/Latino(a) | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Other <i>(specify)</i> : _____ |

EDUCATION *(check all that apply)...*

- | | | | | | | | | | | |
|------------------------------|------------------------------|-------------------------------|------------------------------|--|------------------------------------|---------------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> BA | <input type="checkbox"/> BS | <input type="checkbox"/> BSN | <input type="checkbox"/> CPA | <input type="checkbox"/> DDS | <input type="checkbox"/> MA | <input type="checkbox"/> MBA | <input type="checkbox"/> MD | <input type="checkbox"/> MDS | <input type="checkbox"/> MPH | <input type="checkbox"/> MS |
| <input type="checkbox"/> MSW | <input type="checkbox"/> PhD | <input type="checkbox"/> PsyD | <input type="checkbox"/> RN | <input type="checkbox"/> GED / High School Diploma | <input type="checkbox"/> None / NA | <input type="checkbox"/> 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: _____
SST Completion Date: _____
SST: Spanish-language CET

SESSION DETAILS *(Provide all numbers and requested dates [MM/DD/YYYY]).*

Number of Risk Assessments Sessions: _____ **Date of First RA Session:** _____
Number of Disclosure Sessions: _____ **Most Recent Session:** _____

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.)
 Grandfathered (until 4/9/06)

Certification Date: _____
Last PCT Date: _____
Next PCT Due: _____
PCT: Phlebotomy Competency Testing

Please Fax the form to: Oleg Martynov, OAPP Provider Support Services Division,
Tel: (213) 351 8068 and Fax: (213) 738 6571 after completion.