SAMPLE TIMS TRAINING PARTICIPANT REGISTRATION FORM

To be completed by Participant:

First Name: ______________________

Middle Name: ______________________

Last Name: ______________________

Date of Birth: ______/______/______
Day / Month / Year

National ID Number: ______________________

Payroll ID Number: ______________________

Other ID: ______________________

Gender
☐ Male
☐ Female

Current Home Address

Line 1 ______________________

Line 2 ______________________

Country: ______________________

Province: ______________________

District: ______________________

City: ______________________

Postal Code: ______________________

Home phone: ______________________

Work phone: ______________________

E-mail Address: ______________________

What type of health professional are you? ☑ Check only one current qualification.	
Nurse	☐ Student ☐ Auxiliary ☐ Enrolled/Registered/Degree ☐ Other
Midwife	☐ Student ☐ Enrolled/Registered/Degree ☐ Other
Nurse/Midwife	☐ Student ☐ Enrolled/Registered/Degree ☐ Other
Paramedical	☐ Student ☐ Clinical Officer ☐ Lab Technician ☐ Other
Physician	☐ Intern/Resident ☐ General ☐ OB/GYN ☐ Other
Other	☐ Health Services Administrator ☐ Other, specify:__________

What is your primary job/responsibility? ☑ Check only one current responsibility.	
Health Care Provider	☐ Student ☐ Clinical Provider ☐ Counselor/social worker ☐ Other
Trainer	☐ Clinical Trainer ☐ Other
Teacher/Faculty	☐ Nursing Faculty ☐ Midwifery Faculty ☐ Medical Faculty ☐ Clinical Preceptor/Instructor ☐ Other
Administrator/Manager	☐ Supervisor ☐ Administrator ☐ Other

Where do you primarily work?

Facility Name: ______________________

Line 1 ______________________

Line 2 ______________________

Country: ______________________

Province: ______________________

District: ______________________

City: ______________________

Postal Code: ______________________

Facility Type: ☐ Hospital ☐ Health Center/Clinic/Dispensary ☐ Medical/Nursing/Midwifery/Other School ☐ Training Center ☐ Other

Facility Phone: __ **Fax:** __

Sponsor: ☐ Government ☐ NGO/Not-for-Profit ☐ Private/Commercial/For Profit

Year Achieved: ________

Are you currently providing family planning services?
☐ Yes ☐ No

Have you ever attended any other family planning training courses?
☐ Yes ☐ No

Are you employed by the Ministry of Health?
☐ Yes ☐ No

If yes, year you began working for the Ministry of Health: ________

Do you currently provide clinical services? ☐ Yes ☐ No

If yes, what clinical services do you provide?

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The following information to be completed by Trainer and training program staff:

Assessment Scores:

Pre-Training Assessment Score: __________

Mid-Training Assessment Score: __________

Post-Training Assessment Score: __________

Course Participation Costs:

Subsistence/Per Diem: $__________

Time Off: $__________

Tuition: $__________

Other: $__________

Total: $__________

Choose one, A, B, or C, according to training activity type. ☑ Check only one.

A. Workshop	**B. Training Skills Course**	**C. Clinical Skills Course**
Participant: ☐ Completed activity	**Participant successfully completed this course and is now a candidate:** ☐ Clinical trainer ☐ Advanced trainer ☐ Master trainer ☐ Classroom faculty ☐ Clinical preceptor	**Participant:** ☐ is competent ☐ is not competent **to provide the following clinical service(s) assessed at this training event:** ______________________________ ______________________________ ______________________________ ______________________________ ______________________________ ______________________________

Comments regarding this participant: ______________________________

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Trainer Name: ______________________________ **Trainer Signature:** ______________________________