Registration Information
Continuing Professional Education

NF AETC
A Partner of the SE AETC Network

AETC is required to report information about program participants, per Federal requirements. Data will be kept private to the extent allowed by law and will be referenced periodically to evaluate the effectiveness of AETC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.

Title: _____

Location: _____

Date

First Name	Middle Initial	Last Name	Participant Type (select one)
			☐ Healthcare/ Professional/Worker ☐ Student ☐ Other_____

Ethnicity (select one)
☐ Non Hispanic/Latino ☐ Hispanic/Latino

Professional License (Prefix included)

What is your racial background? Select all that apply
☐ American Indian/Alaskan Native
☐ Asian
☐ White/Caucasian
☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander

What is your gender? Select one
☐ Transgender ☐ Male ☐ Female

Date of Birth Please (MM/DD/YYYY)

Employer Name

Permanent Email address

Work/ Practice Location(s)Address	City and State	County	Zip code

Health Profession / Worker Discipline (select only one)

☐ Dentists
☐ Dental Hygienists
☐ Dietitians/ Nutritionists
☐ First Responders (EMT, Paramedic, Fire Rescue, HazMat)
☐ Marriage and Family Therapists
☐ Medical Assistants
☐ Nurses (Licensed/Practical)
☐ Nurses (Registered)
☐ Nurse Midwives
☐ Nurse Practitioners
☐ Pharmacists
☐ Physicians, Allopathic Medicine
☐ Physicians, Osteopathic Medicine
☐ Physician Assistants
☐ Professional Counselors
☐ Psychiatrists
☐ Psychologists
☐ Respiratory Therapists
☐ Social Workers
☐ Student - Health Professions
☐ Unknown
☐ Other Please Specify _____ _____

Does your participation in this activity meet licenser, certification, employer, or professional education requirements?

☐ Yes ☐ No