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?
_____
_____
_____

SAMPLE TIMS TRAINING PARTICIPANT REGISTRATION FORM

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

Assessment Scores:		**Course Participation Costs:**	
Pre-Training Assessment Score:	_____	**Subsistence/Per Diem:**	**$**_____
Mid-Training Assessment Score:	_____	**Time Off:**	**$**_____
Post-Training Assessment Score:	_____	**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: _____

_____

_____

Trainer Name: _____ **Trainer Signature:** _____