Start Application Form and Submit

Please note: This form cannot be saved so plan to fill it out and submit it all in one go. And remember to prepare ahead of time by printing the PDF version.

* Required

1. Tell us about you

First Name / Given Name *

[   ]

Last Name / Family Name *

[   ]

Suffix *

[RN   ▼]

If you are a non-U.S. clinician, please tell us where and when you received your medical degree, and for how long you have been practicing. *

If your country has a professional registry, please provide your identification number along with the name of the certification agency. If you are not a clinician, please tell us about your expertise area.

[   ]

If you are a U.S. licensed medical provider, please provide your NPI number.

[   ]

Preferred Email Address *

[   ]

Phone Number *

[   ]

What is/are your medical specialty(ies) *
If applicable, if none please specify your area of expertise

[   ]

Have you ever used UpToDate? *

[yes ▾]

If you use other evidence-based medicine information service(s), please enter their name here.

[   ]

2. Tell us about your organization

The name of your organization *

[   ]

Your organization is: *
Please check one

☐ A government agency

☐ A university, college, or other education

☐ A non governmental organization (NGO)

☐ A public hospital

☐ A mission hospital

☐ A group/family practice

☐ Other: [   ]

Country *

Country of registration for your organization/where the headquarters are located.

[   ]

Website

If your organization does not have a website, you can also share a link to a social media page or other information page.

[   ]

What services are provided by your organization? *

Please check all that apply

- ☐ HIV/AIDS
- ☐ PMTCT services
- ☐ Tuberculosis
- ☐ Malaria
- ☐ Primary Care
- ☐ Maternal and Women Health
- ☐ Family Planning services
- ☐ Children Health (inc. <5)
- ☐ Immunization
- ☐ Home-based care
- ☐ Palliative care
- ☐ Mental health
- ☐ Laboratory services
- ☐ Pharmacy services
- ☐ Food and Nutrition
- ☐ Patient Education
- ☐ Education
- ☐ HIV Counseling and testing services
- ☐ Substance abuse
- ☐ Environmental Health
- ☐ Outreach programs
- ☐ Other: [   ]

What is the payment model for these services? *

Please check one or specify if "Other"

○ Fee/Out-of-pocket payment: each service is priced separately

○ Fee/Out-of-pocket payment: all services covered under a single fee based on patients' income/status

○ Fee/Out-of-pocket payment: all services covered under a single fee NOT based on patients' income/status

○ Covered by insurance but co-pay required

○ Free for all services with insurance

○ Free for all services without insurance

○ Don't know/Not sure

○ Other: [   ]

3. Why does your organization/team need a donated subscription to UpToDate?

What is your title within the organization? *

[   ]

Please describe your role. *

For example, are you supervising the clinical team at one or multiple sites? How many clinicians do you supervise? Are you responsible for medical training? How many students access your library? Please be as precise as possible.

[   ]

Country where you work

If different from country of registration/where the headquarters are located.

[   ]

Name of the site where you work and mailing address *

Preferably not a PO Box

[text area]

Number of sites (excluding homes) under your supervision/where you envision usage of UpToDate. *

These can be medical sites where there are shared computers, offices with a network of computers, etc.

- ☐ 1 > 5
- ☐ 6 > 10
- ☐ 11 > 25
- ☐ More than 25
- ☐ Other: [_____]

On average, how many patients are seen a these sites each month? *

Please provide number of patients or number of visits if number of patients is not available. If you organization does not provide medical services, please enter N/A.

[_____]

What proportion of these sites is rural vs. urban? *

Please choose the most appropriate.

[mostly urban ▼]

Who do you envision using UpToDate? *

Please specify type and number (e.g. Students; Medical Officers; Trainees; Clinical Officers; Physicians; Nurses; Assistants; etc.) - If none, please specify

[text area]

Why does your organization/team need an UpToDate subscription? *

Please make the case for a donated subscription. You can include links to websites as appropriate and send photos at utdgrant@globalhealthdelivery.org (just make sure to send it from the preferred email address you indicated above).

Clinicians with your team/organizations are: *

Choose most appropriate.

0% to 10% local ▾

Where will UpToDate be used? *

For example, on the rounds of the hospital or your training center?

What resources are currently available at your organization for medical education and training? *

e.g. training budget, books, journal subscriptions.

What infrastructure/utilities are available to you and your team/group? *

	Available	Not available
Vehicles provided by the organization	◯	◯
Landline phones	◯	◯

We use our own mobile phones or handheld devices	◉	◉
We use our own computers with Internet	◉	◉
Handheld devices provided by the organization	◉	◉
Mobile phones provided by the organization	◉	◉
Computers provided by the organization	◉	◉
Computers with Internet connection provided by the organization	◉	◉
Fax machines	◉	◉
Shared/Common computers without Internet	◉	◉
Shared/Common computers with Internet	◉	◉

Your reference contact *

Please give us the name, role, and contact information of a legal representative for your organization (e.g. CEO, COO, Legal Counsel, Executive Director, Dean) that can confirm your status at this organization. As much as possible, please provide an institutional email address (not Gmail or Yahoo). This person may be contacted as part of the review process.

Your secondary reference contact

If you have another professional contact who can act as a reference, please enter his/her name, role, and contact information details here.

Submit