THE INFECTIOUS DISEASES INSTITUTE

College of Health Sciences, Makerere University

Kampala, Uganda

– IDI Training Program –

Registration Form

Section A: Personal Profile			
Surname	First Name	Gender: Female: ☐ Male: ☐	Date of Birth: __/__/____ D M Y
Address (or P.O Box)		City (with postal code if applicable)	Country
District (Uganda Residents Only)		Nationality	Country of Residence
E-mail Address:		Phone # (include country code)	Fax# (include country code)
Passport number:			
Profession (*Tick all applicable options*): ☐Specialist _____*Specify* ☐ Medical Doctor ☐Clinical Officer ☐Registered Nurse ☐Registered Midwife ☐Enrolled Nurse M/W ☐Laboratory scientist ☐Laboratory Technologist ☐Laboratory Technician ☐Laboratory Assistant ☐Pharmacist ☐Dispenser ☐Counselor ☐Social Worker ☐Allied Health Worker _____ *Specify*		Military Service Member? Yes: ☐ No: ☐ (*If yes, please indicate nation, branch, and rank*)	
Name of course registering for: _____		Start date of training: __/__/____	
Employer Name & Address:		Employer agency type: ☐ Government Agency ☐ Military ☐ Non governmental Org (NGO) ☐ Faith Based Org ☐ Private for profit ☐ Teaching Hospital ☐ Regional/District Hospital ☐ Health centre IV (Major health centre) ☐ Dispensary or Health Centre I-III ☐ Community based health services ☐ Other _____ *specify*	
Location of agency ☐ Urban ☐ Rural		Number of employees in your agency _____	

What is the average number of patients you see per day at your facility? _____	Name Address & Phone # of sponsor
Sponsor agency type: ☐ Government Agency ☐ Military ☐ Non governmental Org (NGO) ☐ Faith Based Org ☐ Private ☐ Other _____ *specify*	How did you learn about IDI? _____

Section C: Previous Training

HIV/TB	Date	Malaria	Date	Laboratory	Date
☐Management of HIV programs		☐Management of complicated malaria		☐HIV Counseling and Testing	
☐HIV prevention		☐Management of uncomplicated malaria		☐Laboratory Techniques in HIV/AIDS	
☐HIV testing and counseling		☐Management of malaria in pregnancy		☐QA and QC in Laboratory Services	
☐HIV care		☐Malaria diagnostics		☐Good Laboratory Practice	
☐Community based HIV care				☐Training of Trainers	
☐ARV in HIV management				☐Clinical Laboratory Management	
☐PMTCT				☐Monitoring & Evaluation	
☐HIV logistics management				☐Others (specify)	
☐Palliative care					
☐Training of trainers					
☐Research					

Section E: What area(s) of practice are you involved in?

HIV/TB	Malaria	Laboratory
☐Management of HIV programs	☐Management of complicated malaria	☐HIV Counseling and Testing
☐HIV prevention	☐Management of uncomplicated malaria	☐Laboratory Techniques in HIV/AIDS
☐HIV testing and counseling	☐Management of malaria in pregnancy	☐QA and QC in Laboratory Services
☐HIV care	☐Malaria diagnostics	☐Good Laboratory Practice
☐Community based HIV care		☐Training of Trainers
☐ARV in HIV management		☐Clinical Laboratory Management
☐PMTCT		☐Monitoring & Evaluation
☐HIV logistics management		☐Others (specify)
☐Palliative care		
☐Training of trainers		
☐Research		

Are you involved in the training of other health care workers? Yes: ☐ No: ☐
If yes please describe training activities you are engaged in:

Are you involved in Continuing Professional Education? Yes: ☐ No: ☐
If yes please describe training activities you are engaged in:

Are you involved in the management of a programme? Yes: ☐ No: ☐
If yes, outline your responsibilities:

After completion of this training, what area of professional services do you plan to improve?

Have you ever done a course at IDI? Yes: ☐ No: ☐

If yes, what course(s): _____
(Include dates)

I _____(Full Name) herby certify that the above information is true and constitutes a valid description of my experience and qualifications

_____
Signature
___/____/_____
Date

For more information please contact:

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