Center for Health Training

2008 Texas DSHS Clinical Conference
Registration Form
Part 1 (Required)
Questions? Call 512/474-2166 or email workshop@jba-cht.com

Make additional copies as needed.
Please type or print in ink, one character per box.

Total Fees Enclosed: $

Participant's First Name: M.I.:

Participant's Last Name:

First Name for Nametag:

Job Title/Position:

Work Phone: – – X

Fax: – –

E-mail address:

Agency Name:

Agency Address:

City State Zip

My agency is (check all that apply):

- ☐ a Texas DSHS-funded family planning provider
- ☐ a Texas DSHS-funded BCCS provider

What is your race/ethnicity? Check all that apply. *Optional: for statistical purposes only.*

- ☐ African American/Black
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Other (specify):_____

Please identify any specific topics, issues, or problems you would like to see addressed in this workshop.

Please describe any special needs you have (e.g., deaf interpreter, access restrictions) so that CHT may accommodate you.

1. Fax this form to our Registration Line at 512/989-9860.
Then...
2. Mail this form with your registration fee, payable to Center for Health Training, to

Center for Health Training
1106 Clayton Lane, Suite 410-E
Austin, TX 78723

0952011143

Center for Health Training

2008 Texas DSHS Clinical Conference
Clinical Practica Registration Form
Part 2 (Optional)
Questions? Call 512/474-2166 or email workshop@jba-cht.com

Make additional copies as needed.
Please type or print in ink, one character per box.

Please complete this form to apply for one or both of the clinical practica at the 2008 Texas DSHS Clinical Conference. Register for the conference first (registration form part 1), as only conference attendees may qualify for acceptance to the practica. Please note that the Contraceptive Implant Insertion practicum is available only for PAs, NPs and MDs.

CHT will notify practicum applicants of their status by April 15, 2008.

First Preference (Check one)

☐ IUD Insertion
☐ Contraceptive Implant Insertion

Second Preference (Check one)

☐ IUD Insertion
☐ Contraceptive Implant Insertion

Participant's First Name: M.I.:

Participant's Last Name:

Practice Address:

City State Zip

Practice Phone: – –

State License #:

Physician's Specialty:

Home Address:

City State Zip

Home Phone: – –

E-mail address:

Fax this form to our Registration Line at 512/989-9860.

Questions? Call 512/474-2166 or email workshop@jba-cht.com

Center for Health Training
1106 Clayton Lane, Suite 410-E
Austin, TX 78723

5519334628