

PROJECT REACH

Course Application Form

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|--|----------------------------|
| Name (as you would like it to appear on your certificate): | Last 4 digits of your SS#: |
| Agency: | Agency: |
| Address: | Work Phone: |
| City/State/ZIP: | Email Address: |

| COURSE TITLES | DATES | COURSE FEE |
|---------------|-------|------------|
| 1. | 1. | |
| 2. | 2. | |
| 3. | 3. | |
| 4. | 4. | |
| 5. | 5. | |
| 6. | 6. | |

What is your field/profession? Please Choose One:

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV Prevention Professional | <input type="checkbox"/> MH Counselor | <input type="checkbox"/> Program Director/Administrator |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Clinical Director/Supervisor |
| <input type="checkbox"/> Physician | <input type="checkbox"/> HIV Case Manager | <input type="checkbox"/> State Agency Representative |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Substance Abuse Counselor | <input type="checkbox"/> Outreach Worker |
| <input type="checkbox"/> Other (Please Specify): _____ | | |

Are you on the RICPG?

- CPG Member
 Task Force Member
 Not a Member

I _____ (name) understand that:

Failure to attend the course will result in loss of deposit. _____ (Initial)

Attendance lists will be provided to Supervisors and RI Dept. of Health. _____ (Initial)

_____ (Participant Signature) _____ (Date)

_____ (Agency Supervisor) _____ (Date)

***Only forms received by mail will be accepted. Faxed or email forms are not accepted.
Deposit must accompany this form in order to be processed.***

Please send completed registration to:
 Project REACH c/o DATA of RI
 200 Metro Center Blvd, Unit 10, Warwick, RI 02886

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|---|
| Office Use Only: Ch # _____ Amount _____ |
| Completed _____ |