



Certificate Student

Trainee Registration Form

Registration Date ____/____/____

Name _____ WVU ID# _____

Birth Date ____/____/____ Gender Male Female Ethnicity Hispanic

Race (White, Black, Asian, Am. Indian, Multi-racial, Other) _____

First Day of Training ____/____/____ (month/day/year)

Anticipated Last Day of Training ____/____/____ (month/day/year)

*Current Contact Hours _____ Total Hours per Year (20 per wk x 36 wk = 720 hrs)

Long Term (300+ Hrs) Intermediate (40-299 Hrs) Short Term (1-39 Hrs)

Your Discipline _____ Enrollment Status Full-Time Part-Time

Current Academic Level _____ Degree Program (BA, MS, PhD etc) _____

Academic Degree(s) Achieved _____ Year Awarded _____

Are you a LEND Trainee? Yes No

Are you a CED Pre-Service Prep and Continuing Education Trainee? Yes No

Position Title at Admission: _____

Position Setting at Admission: _____

(Student, Schools, Post-Secondary, CED/LEND, Government, For-Profit, Non-Profit, Public Health/Title V, Hospital, Private Practice)

Personal Relationship with Disabilities: Is the trainee a

- | | |
|--|--|
| <input type="checkbox"/> Person with a disability | <input type="checkbox"/> Person with a special health care need (SHCN) |
| <input type="checkbox"/> Parent of a person with a disability | <input type="checkbox"/> Parent of a person with a SHCN |
| <input type="checkbox"/> Family member of a person with a disability | <input type="checkbox"/> Family member of a person with a SHCN |

Support Type:

- | | | | |
|----------------------|--|--|---|
| (core grant funding) | <input type="checkbox"/> MCH | <input type="checkbox"/> ADD | <input type="checkbox"/> OSEP |
| (Other funding) | <input type="checkbox"/> Clinical Fees | <input type="checkbox"/> Academic Dept | <input type="checkbox"/> Fellowship/Scholarship |
| | <input type="checkbox"/> Internship | <input type="checkbox"/> Other | <input type="checkbox"/> None/Not Applicable |

Stipend \$ _____ Tuition & Fees \$ _____ Travel \$ _____ Total \$ _____

Type of Participation: Didactic Clinical Research Practicum/Field work Other _____

Which of the following training curricula is the trainee completing (independent of trainee's funding source) **MCH/LEND** **CED/ADD** **OSEP** **Pediatric Residency** **Other** _____ **Not Applicable**

CED Supervisor: _____

Faculty Advisor: _____

Training Site: _____

Informed consent and Confidentiality Statement: I understand that the information disclosed on this form might be used to compile national statistics on training programs such as ours, and that it will not be used for any other purpose without my explicit consent. I also understand that it is incumbent upon all trainees at CED to keep all client information, both written and verbal, in strict confidence during their tenure at CED and thereafter.

Signature: _____ **Date:** _____

Current Address _____

Street

City

State

Zip

Phone _____ WVU MIX E-mail address _____

Permanent Address (parents or permanent contact, for follow-up)

Permanent Address _____

Street

City

State

Zip

Phone _____ Alternate E-mail address _____