

National Laboratory Training Network Site Representative Registration Form

Form Approved
OMB No. 0920-0017
Exp. Date: 03/31/10

(Please Type or Print.)

Select (√) desired program(s)		
CoNS: How to Get the Maximum ID for the Minimum Effect October 16, 2007 (588-327-07)	The Latest on Antimicrobial Susceptibility Testing of CoNS October 23, 2007 (588-328-07)	Clinical Significance of Cultures Growing CoNS October 30, 2007 (588-329-07)
All three teleconferences (588-330-07)		

Applicant Information- for site facilitator

Title: (Dr./Mr./Miss/Ms./Mrs.) **First Name:** **M.I.:** **Last Name:**

Position Title: **State Licensure Number (If applicable):**

Employer's Name:

Mailing Address: *(Please specify, Employer's or your Home address?)*

City: **State/Country:** **Zip:**

Work Telephone Number: **Work Fax Number:**

E-mail Address: *(Applicant must provide an e-mail address to receive an NLTN confirmation of registration.)*

(To receive future training event notifications, please circle, YES)

(Please review all options in the three categories before circling the one most appropriate to each category.)

- | | |
|--|---|
| <p>Occupation</p> <ul style="list-style-type: none"> 01 Physician 02 Veterinarian 04 Laboratorian 05 Nursing Professional 06 Sanitarian 08 Administrator 11 Safety Professional 13 Educator 14 Epidemiologist 15 Environmental Scientist 12 Other _____ <p>Education Level (Highest Completed)
Degree</p> <ul style="list-style-type: none"> 04 Associate 05 Bachelor 06 Masters 07 Doctoral (M.D.) 08 Doctoral (Other than M.D.) 09 Technical/Hospital School 03 Some College 02 High School Graduate 01 Some High School 10 Other _____ | <p>Type of Employer</p> <ul style="list-style-type: none"> 01 Public Health Department (State or Territorial) 03 Public Health Department (Local, City or County) 04 Government (Other Local, not City or County) 05 Centers for Disease Control and Prevention 09 U.S. Food and Drug Administration 11 U.S. Department of Defense 12 Veterans Administration Medical Center/Hospital 15 Other (Federal Employer) _____ 16 Foreign 19 College or University 21 Private Industry 23 Private Clinical Laboratory 24 Physician's Office Laboratory/Group Practice 33 Hospital 28 Health Maintenance Organization 31 Non-profit 32 Unemployed or Retired 34 Environmental Laboratory 35 Veterinary Laboratory 36 Agricultural Laboratory 30 Other _____ |
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The information requested on this form is collected under the authority of 42 U.S.C., Section 243 (CDC). The requested information is used only to process your training registration and will be disclosed only upon your written request.

Continuing education credit can only be provided when all requested information is submitted. Furnishing the information requested on this form is voluntary.

Public reporting burden for this collection of information is estimated to average five minutes per response, including the time for reviewing instructions, searching existing data sources gathering and maintaining the data needed, and completing and reviewing the collection of information.

An agency may not conduct or sponsor, and a person is not to respond to a collection of information, unless it displays a currently valid OMB control number.

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Office, 1600 Clifton Road, N.E., Mail Stop D24, Atlanta, GA 30333 ATTN: PRA (0920-0017).

Register Early!

Registration Fee:
\$70.00/site/teleconference
\$180.00/site for all three teleconferences

Registration Deadline:
 Payment Information (Please check one.)

- Enclosed is my check or money order (payable to APHL).
 Bill my Credit Card.
 Select one.
 VISA
 MasterCard
 American Express

Submit your registration form to:

Fax: 240-485-2700
Mail: NLTN Registrar
 PO Box 79117
 Baltimore, MD 21279-0117

Need further information???

Registration questions call 240-485-2727
 Program content questions call 617-983-6285

Credit Card Information

Card Holder's Name
Card Number
Expiration Date
Signature
Date
Amount of Payment