TRANSITION TRAINING APPLICATION

CONTACT INFORMATION

Name: _____

Institution: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email: _____

CURRENT ROLE

- ☐ A geneticist in practice? Graduation year: _____
- ☐ A genetic counselor in practice? Graduation year: _____
- ☐ Other _____

TRANSITION

Do you have experience with transition practices?

- ☐ Yes, healthcare transition is a standard part of my practice
- ☐ Yes, but limited
- ☐ No

What are you interested in gaining from this training?

Will you be able to travel to a hands-on session on February 16-17, 2017 in Sioux Falls, SD?

☐ Yes ☐ No ☐ Not Sure

Please note that by participating in the training you agree to provide follow-up feedback to Heartland and the Center for Disabilities at the University of South Dakota.

☐ ***I agree to implement the information learned with my patients over a period of three months and submit requested data.***

PLEASE RETURN YOUR COMPLETE APPLICATION TO ANAYELI@UAMS.EDU BY NOON THURSDAY, JANUARY 12, 2017. YOU WILL BE NOTIFIED OF THE STATUS OF YOUR APPLICATION NO LATER THAN FRIDAY, JANUARY 13, 2017. THANK YOU!