THE INFECTIOUS DISEASES INSTITUTE

College of Health Sciences, Makerere University

Kampala, Uganda

– IDI Training Program –

Registration Form

Section A: Personal Profile			
Surname	First Name	Gender: Female: ☐ Male: ☐	Date of Birth: __/__/____ D M Y
Address (or P.O. Box)		City (with postal code if applicable)	Country
District (Uganda Residents Only)		Nationality	Country of Residence
E-mail Address:		Phone # (include country code)	Fax # (include country code)
Council Registration Number:			
Profession (*Tick all applicable options*): ☐Specialist ________________________*Specify* ☐ Medical Doctor ☐Clinical Officer ☐Registered Nurse ☐Registered Midwife ☐Enrolled Nurse M/W ☐Nursing Assistants ☐Laboratory scientist ☐Laboratory Technologist ☐Laboratory Technician ☐Laboratory Assistant ☐Pharmacist ☐Dispenser ☐Counselor ☐Social Worker ☐Allied Health Worker _______________ *Specify* ☐ Other ______________________ Specify		Military Service Member? Yes: ☐ No: ☐ (*If yes, please indicate nation, branch, and rank*) What is the language of instruction that you are most comfortable with? 1. English ☐ 2. Swahili ☐ 3. French ☐ 4. ☐ Others ______________________ Specify	
Name of course registering for: ________________________________		Start date of training: ___/___/____	End date of training: ___/___/____
Employer name & address: Place of work / Facility:		Employer agency type: ☐ Government Agency ☐ Military ☐ Non-Governmental Organisation (NGO) ☐ Faith-based Organisation ☐ Private for profit ☐ Teaching Hospital ☐ Regional/District Hospital ☐ Health Centre IV (Major health centre) ☐ Dispensary or Health Centre I-III ☐ Community-based health services ☐ Other __________________________ *specify*	
Location of agency ☐ Urban ☐ Rural		Number of employees in your agency ___________	

What is the average number of patients you see per day at your facility? ____________________	Name, address & phone number of sponsor:
Sponsor agency type: ☐ Government Agency ☐ Military ☐ Non-Governmental Organisation (NGO) ☐ Faith-based Organisation ☐ Private ☐ Other ______________________________ *specify*	How did you learn about IDI? __________________________________

Section C: Previous Training

1.HIV/TB	Date	2.Malaria	Date	3.Laboratory	Date
☐Management of HIV programs		☐Management of Complicated Malaria		☐HIV Counseling and Testing	
☐HIV Prevention		☐Management of Uncomplicated Malaria		☐Laboratory Techniques in HIV/AIDS	
☐HIV Testing and Counseling		☐Management of Malaria in Pregnancy		☐QA and QC in Laboratory Services	
☐HIV Care		☐Malaria Diagnostics		☐Good Laboratory Practice	
☐Community-based HIV Care				☐Training of Trainers	
☐PMTCT				☐Others	
☐HIV Logistics Management					
☐Palliative Care					
☐Training of Trainers					
☐Research					
4. Pharmacy		**5.Systems Strengthening**		**6.Others_____ (specify)**	
☐Medicine Logistics		☐Monitoring & Evaluation			
☐Clinical Pharmacy		☐Data Management			

Section E: What area(s) of practice are you involved in?

1.HIV/TB	2.Malaria	3.Laboratory
☐Management of HIV Programmes ☐HIV Prevention ☐HIV Testing and Counseling ☐HIV Care ☐Community-based HIV Care ☐ARV in HIV Management ☐PMTCT ☐HIV Logistics Management ☐Palliative Care ☐Training of Trainers ☐Research	☐Management of Complicated Malaria ☐Management of Uncomplicated Malaria ☐Management of Malaria in Pregnancy ☐Malaria Diagnostics	☐HIV Counseling and Testing ☐Laboratory Techniques in HIV/AIDS ☐QA and QC in Laboratory Services ☐Good Laboratory Practice ☐Training of Trainers ☐Clinical Laboratory Management
4. Pharmacy ☐Medicine Logistics ☐Clinical Pharmacy	**5. Systems Strengthening** ☐Monitoring & Evaluation ☐Data Management	**4. Others** ☐Monitoring & Evaluation ☐ Data Management ☐Research ☐Others…………….. (specify)

Are you involved in the training of other health care workers or Continuing Professional Education activities? Yes: ☐ No: ☐
If yes, please describe training activities you are engaged in:

Are you involved in the management of a programme? Yes: ☐ No: ☐
If yes, outline your responsibilities:

After completion of this training, what area of professional services do you plan to improve?

Have you ever undergone any training by IDI? Yes: No:
If yes, what course(s): ____________________________________
(Include dates)

I ______________________________ (Full Names) hereby certify that the above information is true and constitutes a valid description of my experience and qualifications.

____
Signature
___/____/________
Date

For more information, please contact:

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