**UCEDD/LEND Trainee Registration Form 2019**

**Intermediate/Long Term Trainee**

*National Information and Reporting System (NIRS)*

*July 1, 2018 – June 30, 2019 = FY 2019 Reporting Period*

*Response Required*

**Trainee Contact Information**

<table>
<thead>
<tr>
<th>First Name/ Middle Initial</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Street Address</td>
<td>City, State, ZIP Code</td>
</tr>
<tr>
<td>County of Origin (i.e. Dane County)</td>
<td>Current Phone</td>
</tr>
<tr>
<td>Personal (Primary) E-Mail Address</td>
<td>School (Secondary) E-Mail Address</td>
</tr>
<tr>
<td>Former name, if applicable</td>
<td></td>
</tr>
</tbody>
</table>

**Academic Degree or Credentials ALREADY Achieved** *(Examples include completed: AuD, BA, BSW, Consumer, High School, MA, MD, Parent, PhD, RN, SLP, etc): ___________________________*

**Permanent Contact Information** *(often referred to as your “emergency” contact)*

<table>
<thead>
<tr>
<th>First and Last Name</th>
<th>Relationship to Trainee <em>(i.e. Your Parent, Your Partner, etc.)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City, State, ZIP Code</td>
</tr>
<tr>
<td>Current Phone</td>
<td>Personal (Primary) E-Mail Address</td>
</tr>
</tbody>
</table>

Date of Birth: ___/___/___

*I Identify My Gender as: _____Male or _____Female or __________________ or _____Unrecorded*

*Ethnicity* (check one): *Hispanic* is an ethnic category for people whose origins are in the Spanish-speaking countries of Latin America or who identify with a Spanish-speaking culture. Individuals who are Hispanic may be of any race.

_____ Hispanic  _____ Non-Hispanic  _____Unrecorded

*Return FY 2019 Form to Julie Schears*
* Race (check one):
  _____ White refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa.
  _____ Black or African American refers to people having origins in any of the Black racial groups of Africa.
  _____ American Indian and Alaskan Native refer to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
  _____ Tribe: ____________________
  _____ Asian refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g. Asian Indian).
  _____ Native Hawaiian and Other Pacific Islander refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
  _____ More than one race includes individuals who identify with two or more racial designations.
  _____ Unrecorded is included for individuals who are unable to identify with the categories.

* Primary Language
  Do you speak a language other than English at home?
    _____ No  _____ Yes, Spanish  _____ Yes, another language (please identify): ____________________
  **If YES, how well do you speak English?
    _____ Very well  _____ Well  _____ Not well  _____ Not at all

* Trainee’s Position Setting at Admission (before you joined our training program were you a student, or were you working at a hospital, or a school, etc.):  _____ Student ____________________ /Other (explain)

* Trainee’s Position Title at Admission: (e.g. PA, Pediatric Resident, LEND Trainee, SW Fieldwork Student, Genetic Counseling Student, Student teacher) ____________________ / ____________________

* Personal relationship with Disabilities:
  Are you a ... (Please check all that apply)
    _____ Person with a disability
    _____ Person with a special health care need
    _____ Parent of a person with a disability
    _____ Parent of a person with a special health care need
    _____ Family member of a person with a disability
    _____ Family member of a person with a special health care need
    _____ None of the above

Current Place of Employment: ____________________ / ____________________
Current Job Position/Title: ____________________ / ____________________

* Academic Level
  Check enrollment status List Degree Program (BA, MA, AuD, PhD, MSW, etc.)
    _____ Undergraduate ____________________
    _____ Masters ____________________
    _____ Doctoral ____________________
    _____ Post Doctoral ____________________
    _____ Other ____________________
    _____ Non Degree ____________________

* Academic Enrollment Status: (Check one)  _____ Full-Time Student  _____ Part-Time Student  _____ Non-Student

* Return FY 2019 Form to Julie Schears
*Discipline: (Check one)

___ Audiology  ___ Medicine-Pedicatric Pulmonology
___ Biological Sciences  ___ Medicine: General
___ Dentistry-Pediatric  ___ Medicine: Pediatric
___ Dentistry-Other  ___ Mental and Behavioral Health
___ Disability Studies  ___ Nursing
___ Education/Special Education  ___ Nursing-Family/Pediatric Nurse Practitioner
___ Education: Administration  ___ Nursing-Midwife
___ Education: Early Intervention/Early Childhood  ___ Nursing-Other
___ Education: General Education  ___ Nutrition
___ Epidemiology  ___ Occupational Therapy
___ Family Studies  ___ Pastoral
___ Family Discipline (parent, sibling)  ___ Pharmacy
___ Genetics/Genetics Counseling  ___ Physical Therapy
___ Gerontology  ___ Psychiatry
___ Health Administration  ___ Psychology
___ Human Development/Child Development  ___ Public Administration
___ Interdisciplinary  ___ Public Health
___ Medicine-Adolescent Medicine  ___ Rehabilitation
___ Medicine-Developmental-Behavioral Pediatrics  ___ Respiratory Therapy
___ Medicine-Neurodevelopmental Disabilities  ___ Self-Advocate
___ Other - Please specify: __________  ___ Social Work
___ Other - Please specify: __________  ___ Speech-Language Pathology

*Contact Hours in Training Program

<table>
<thead>
<tr>
<th></th>
<th># Weeks</th>
<th># hours/week</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summer (June – August)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall Semester (August – December)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Spring Semester (Jan – May)</td>
<td></td>
<td></td>
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<tr>
<td>Inter-Session (May – June)</td>
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</table>

*TOTAL Contact Hours: __________

*(Example of Contact Hours: LEND)  

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<th># Weeks</th>
<th># hours/week</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Fall Semester (August – December)</td>
<td>15</td>
<td>10</td>
<td>= 150</td>
</tr>
<tr>
<td>Spring Semester (Jan – May)</td>
<td>15</td>
<td>10</td>
<td>= 150</td>
</tr>
</tbody>
</table>

TOTAL Contact Hours = 300 Training Contact Hours

*Upon completing training you will be: (Check one)

___ Long-Term Trainee? (300+ hours upon completion of training)
___ Intermediate Trainee? (150-299 hours upon completion of training)
___ Intermediate Trainee? (40-149 hours upon completion of training)
___ Short-term trainee? (8 - 39 hours upon completion of training)

*Return FY 2019 Form to Julie Schears
*First Time Registered with Waisman Center?  Yes  No -- (list previous years) _______________________

*Start Date and End Date of training experience at Waisman Center: ______/____/____  to  ______/____/____  
Mo Year  Mo Year

*Are you a UCEDD Trainee?  Yes  No

*Are you a LEND Trainee?  Yes  No  If YES, will you receive MCH Support?  Yes  No

Salary / Stipend (as UCEDD or LEND trainee) $__________
Tuition & Fees (as UCEDD or LEND trainee) $__________
Total $__________

*Support Type  Check all categories to describe any program-related financial support the trainee is currently receiving.
Core Grant Funding  Other Funding
___ MCH Core ___ Clinical Fees
___ MCH Autism Supplement ___ Academic Department
___ AIDD ___ Internship
___ OSEP ___ Fellowship/Scholarship
___ None/Not Applicable ___ Other _______________________

Waisman Center Programs / Clinics you will be affiliated with during your training here:

___ Audiology Services  ___ Act Early Wisconsin
___ Augmentative Communication Aids & Systems (CASC, CDP) Clinic  ___ Birth to 3 Training & Technical Assistance
___ Autism & Developmental Disabilities Clinic  ___ Community Training & Consultation
___ Aural Rehabilitation Therapy  ___ Early Childhood Professional Development
___ Biochemical Genetics Clinic  ___ Early Hearing Detection & Intervention (EHDI)
___ Bone Dysplasia Clinic  ___ Genetic Counseling Master’s program
___ Cerebral Palsy Clinic  ___ Genetics Hub
___ Down Syndrome Clinic  ___ National Professional Development Center on Autism
___ Feeding Team  ___ Pathways to Independence
___ Medical Genetics Clinic  ___ Training activities that include screening, diagnosis & treatment for ASD
___ Neuromotor Development Clinic  ___ Waisman Early Childhood Program (WECP)
___ Newborn Follow-up Clinic  ___ Waisman Regional Resource Center
___ Pediatric Brain Care Clinic  ___ WI MCH LEND program
___ Spasticity & Movement Disorders Clinic  ___ Waisman Research projects
___ Community Outreach Wisconsin – Olin Avenue  Specify: ___ UCEDD  ___ LEND
___ Community TIES  ___ IDDR C  ___ Clinics
___ Community Training & Consultation  Investigator: _______________________
___ LOV-Dane / Choices  ___ Project Title: _______________________
___ Sound Response  ___ Other:
___ Wellness Inclusion Nursing (WIN)  ___ Other:
Type of Participation: (Check all that apply)

___ Didactic
___ Clinical
___ Research
___ Practicum/Field Work
___ Other – Please Specify: _______________________

Which of the following training curricula are you completing?

___ LEND
___ UCEDD
___ OSEP
___ Pediatric Residency
___ Other – Please Specify: _______________________
___ Not Applicable

*Products, Presentations and Posters produced by the Student (July 1, 2018-June 30th, 2019)
Please email Julie Schears information on any products you produce during your traineeship (schears@waisman.wisc.edu)

<table>
<thead>
<tr>
<th>Name of Product and Event (Example: Autism Research Poster at AUCD Conference)</th>
<th>Where it took place &amp; Date (Example: Washington, D.C. / November, 2018)</th>
</tr>
</thead>
<tbody>
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*SUPERVISOR’S NAME: (Printed) ____________________________

*SUPERVISOR’S SIGNATURE: ____________________________

*Date: __________________

Return to: Julie Schears (mailbox is in bank of mailboxes outside of A109, or Inter-D to Room S101F)