

**STRONG CENTER FOR DEVELOPMENTAL DISABILITIES  
TRAINEE APPLICATION FORM**

*LEND is a training grant funded by the U.S. Health Resources and Services Administration (HRSA) through the Maternal Child Health Bureau (MCHB). The following information is required in order to be considered for candidacy.*

**\* Response required**

Date: \_\_\_\_\_

**I. CONTACT INFORMATION**

1. \* First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ \* Last Name: \_\_\_\_\_

2. Former Name: \_\_\_\_\_

3. Date of Birth \_\_\_\_\_

4. \* Current Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

\* Phone (w) \_\_\_\_\_ (h) \_\_\_\_\_

5. Name of Permanent Contact \_\_\_\_\_

6. Relationship of Permanent Contact \_\_\_\_\_

7. \* Permanent Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone (w) \_\_\_\_\_ (h) \_\_\_\_\_

8. \* E-Mail Address (Primary) \_\_\_\_\_

(Secondary) \_\_\_\_\_

9. Expected dates of Training: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

10. Training desired in what discipline:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Health Administration     | <input type="checkbox"/> Family Advocacy          | <input type="checkbox"/> Pediatric Dentistry |
| <input type="checkbox"/> Social Work               | <input type="checkbox"/> Nutrition                | <input type="checkbox"/> Physical Therapy    |
| <input type="checkbox"/> Audiology                 | <input type="checkbox"/> Occupational Therapy     | <input type="checkbox"/> Nursing             |
| <input type="checkbox"/> Education                 | <input type="checkbox"/> Developmental Pediatrics | <input type="checkbox"/> Psychology          |
| <input type="checkbox"/> Speech-Language Pathology | <input type="checkbox"/> Other _____              |  |

11. How did you hear about our training program?

Brochure \_\_\_\_\_

Presentation \_\_\_\_\_ If checked, give date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Letter \_\_\_\_\_ If checked, give date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Professional Journal Advertisement \_\_\_\_\_ Name of Journal \_\_\_\_\_

Internet \_\_\_\_\_ Web Address (if known) \_\_\_\_\_

Other (Please detail) \_\_\_\_\_

12. Personal relationship with people with Disabilities: (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

## II. **DEMOGRAPHIC INFORMATION**

1. \* Gender **M** or **F**

2. \* Race:

- White
- Black or African-American
- American Indian and Alaska Native  
Indian Tribe Name: \_\_\_\_\_
- Asian (includes Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and other Asian)
- Native Hawaiian and Other Pacific Islander (includes Native Hawaiian, Guamanian or Chamorro, Samoan, and other Pacific Islander)
- Two or More Races
- Other

3. \* Ethnicity:

- Hispanic or Latino
- Non-Hispanic or Latino

4. \* Citizenship: A fellow or trainee must be a United States citizen, or, as an alien, must have been admitted to the United States with a permanent resident visa.

Do you meet this requirement?

- Yes  
 No

### III. **ACADEMIC INFORMATION**

1. \* Highest degree achieved at this time \_\_\_\_\_ Discipline of this degree \_\_\_\_\_

Other degree(s): \_\_\_\_\_

Bachelors \_\_\_\_\_

Medical/Doctorate \_\_\_\_\_

Masters \_\_\_\_\_

Specialty Training (*please specify*) \_\_\_\_\_

2. During the training period, will you be pursuing an advanced academic degree/certification?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe \_\_\_\_\_

3. In the past, have you been a teacher or supervisor in higher education courses?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe \_\_\_\_\_

### IV. **EMPLOYMENT**

1. Are you currently employed? Yes \_\_\_\_\_ (*Please continue with question #2*)

No \_\_\_\_\_

2. Are you employed Full-time \_\_\_\_\_ or Part-time \_\_\_\_\_ ?

3. Do you have supervisory responsibilities? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

4. What percentage of time do you spend in each of the following areas?

Direct Service \_\_\_\_\_%

Research \_\_\_\_\_%

Teaching \_\_\_\_\_%

Administrative/Supervisory \_\_\_\_\_%

Private Practice \_\_\_\_\_%

Other \_\_\_\_\_%

5. Current Employment

- a. Name of Organization \_\_\_\_\_
- b. Address \_\_\_\_\_
- c. City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_
- d. Academic title (if applicable) \_\_\_\_\_
- e. Functional title \_\_\_\_\_

6. Primary type of Employment

- Direct Service \_\_\_\_\_ Governmental (*Local, State, Federal*) \_\_\_\_\_
- Private Practice \_\_\_\_\_ Business/Consultative \_\_\_\_\_
- Teaching \_\_\_\_\_ Other (*Specify*) \_\_\_\_\_

**V. DIRECT SERVICES (Fill this out only if you provide direct services)**

- 1. Approximately how many **clients/consumers** do you serve weekly? \_\_\_\_\_
- 2. Approximately how many **hours** of direct service do you perform weekly? \_\_\_\_\_
- 3. With which disability group do you primarily work? (*Please estimate by percentages*)

- MR/DD \_\_\_\_\_% Physical Disabilities (only) \_\_\_\_\_%
- CSHCN \_\_\_\_\_% Other (*Please specify*) \_\_\_\_\_%
- (Children with Special Health Care Needs)

4. What age groups are served by your unit? (*Please estimate by percentages*)

- Prenatal \_\_\_\_\_% 0-2 yrs \_\_\_\_\_% 3 - 5 yrs \_\_\_\_\_% 6-12 yrs \_\_\_\_\_%
- 13 - 21 yrs \_\_\_\_\_% > 21 yrs \_\_\_\_\_%

5. What ethnic groups are served by your unit? (*Please estimate by percentages*)

- Caucasian \_\_\_\_\_% African American \_\_\_\_\_% Hispanic \_\_\_\_\_%
- Native American \_\_\_\_\_% Asian American \_\_\_\_\_% Other (*Please specify*) \_\_\_\_\_%

**VI. LEADERSHIP**

1. Are you currently involved in ongoing research?

- Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, in what topic areas? \_\_\_\_\_

2. Do you provide consultation/technical assistance (*non-direct care services*) to agencies, organizations, or businesses? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Are you currently involved in planning or implementing demonstration projects or new treatment approaches? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide project title, collaborators and funding source. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Are you currently a member of any planning/advisory committees?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list up to three primary committees and describe your most relevant involvement

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5. Professional and Community presentations: \_\_\_\_\_

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6. Membership in professional organizations (*include Officer roles, if applicable*) : \_\_\_\_\_

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**VII. PROFESSIONAL STATEMENT**

Please attach a brief statement describing your career goals, with special attention to the contribution this training program will make toward your achieving your professional objectives.