Trainee Survey FY 2020 - UCEDD Trainees

* Response Required

Contact / Background Information

***Name** (first, middle, last): _____
Previous/Maiden Name: (if Applicable) _____

Current Address (where you would like to be contacted)
***Address1**: _____
Address 2: _____

_____
City State Zip

Phone: (999-999-9999) _____
Primary Email: _____
Secondary Email: _____

What is the name of your current place of employment: _____

What is the name of your current job position/title: _____

Permanent Contact Information (someone at a different address who will know how to contact you in the future, e.g., parents)

***Name of Contact**: _____
Relationship: _____
***Address**: _____
Address 2: _____

_____
City State Zip

***Country** _____
Phone: (999-999-9999) _____

****Race***: (choose 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.

****Ethnicity***: (choose 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** is included for individuals who are unable to identify with the categories

Please answer the following questions as thoroughly as possible. When you have filled out the entire survey, return it to your Center/Program.

Survey

1. Are you a (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
- ☐ Unrecorded

2. Does your current work relate to Maternal and Child Health (MCH) populations (i.e. women, infants and children, adolescents, and their families including fathers and children or young adults with special health care needs)?

☐ Yes ☐ No

3. Does your current work relate to individuals with disabilities?

☐ Yes ☐ No

4. Do you currently work in a public health organization or agency (including Title V)?

☐ Yes ☐ No

5. Does your current work relate to underserved or vulnerable populations? (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, people with disabilities, etc)

☐ Yes ☐ No

6. Select your primary type/setting of employment (select what best describes your current employment):

- ☐ Student
- ☐ Schools or school system (includes EI programs, elementary and secondary)
- ☐ Post-secondary setting
- ☐ UCEDD/LEND/LEAH/PPC/DBP
- ☐ Government agency
- ☐ For-profit
- ☐ Non-profit
- ☐ Hospital
- ☐ Private sector
- ☐ Other: please specify: _____

7. What is the number of individuals with developmental disabilities who are receiving direct services through activities in which you are involved? _____

Leadership Activities

***8. Have you done any of the following activities since completing your training program?**

- ☐ Participated on any of the following as a group leader, initiator, key contributor or in a position of influence/authority: committees of state, national or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
- ☐ Served in a clinical position of influence (e.g. director, senior therapist, team leader, etc.)
- ☐ Provided consultation or technical assistance in MCH areas
- ☐ Taught/mentored in my discipline or other MCH related field
- ☐ Conducted research or quality improvement on MCH issues
- ☐ Disseminated information on MCH Issues (e.g., Peer reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
- ☐ Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- ☐ Procured grant and other funding in MCH areas
- ☐ Conducted strategic planning or program evaluation
- ☐ Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation (provided testimony, educated legislators, etc)
- ☐ None

***9. If you checked any of the activities above, in which of the following settings or capacities would you say these activities occurred? (check all that apply)**

- ☐ Academic
- ☐ Clinical
- ☐ Public Health
- ☐ Public Policy & Advocacy
- ☐ None

***10. If you are currently in the fields of developmental disabilities, and are participating in leadership activities, please select in which of the following settings or capacities these activities occur:**

- ☐ Academic
- ☐ Clinical
- ☐ Public Health
- ☐ Public Policy & Advocacy
- ☐ None

11. Please describe professional achievement(s) that you would attribute to the training program or anything else you'd like us to know about your career

_____

_____

Evaluation of Training Program

I would recommend the training program to others.

☐ 3 (completely agree) ☐ 2 (mostly agree) ☐ 1 (partially agree) ☐ 0 (disagree) ☐ no response

Confidentiality Statement

Thank you for agreeing to provide information that will enable your training program to track your training experience and follow up with you after the completion of your federally-funded training program. Your input is critical to our own improvement efforts and our compliance with Federal reporting requirements. You are currently completing the alternate format paper survey.

Please know that your participation in providing information is entirely voluntary. The information you provide will only be used for monitoring and improvement of the training program. Please also be assured that we take the confidentiality of your personal information very seriously. None of the information that you provide will be used to individually identify you to any outside agency, such as the Maternal Child Health Bureau (MCHB) or Administration on Intellectual and Developmental Disabilities (AIDD). Any information supplied to any other federal agencies or public will be done on an aggregate basis in such a way as to preclude the ability to identify any individual trainee.

If you have any questions, concerns, or need the survey in an alternate format, please contact the Director of the Center from which you received your training or Natalie Martinez at AUCD (nmartinez@aucd.org) or 301-588-8252.

We very much appreciate your time and assistance in helping to document outcomes of the Training Program. We look forward to learning about your academic and professional development.