



Oklahoma Interdisciplinary Leadership Education for Health Professionals Caring for Children with Neurodevelopmental and Related Disabilities (LEND)

The Child Study Center is required to collect information on all its trainees to report to agencies that fund some of the training. Please answer the following questions as accurately and completely as possible.

**OKLAHOMA LEND INTERN
CONTACT INFORMATION (Your information)**

First Name: _____ **Middle Name:** _____
Last Name: _____ **Former Name:** _____
Current Address: _____
Current City: _____ **State:** _____ **Zip:** _____
County of Origin in Oklahoma _____ (before Internship) Check if your origin state is NOT Oklahoma

Because students often move to a location near the school they will be attending, trainees are asked to provide the name of the county they relocated from to attend school, rather than their current county of residence.

Primary e-mail: _____ **Secondary e-mail:** _____
Primary Phone #: (____) _____ **Secondary Phone #:** (____) _____

**PERMANENT CONTACT INFORMATION
(Someone not living with you)**

Name of Permanent Contact: _____ **Relationship:** _____
Permanent Address: _____
Permanent City: _____ **Permanent State:** _____ **Zip:** _____
Permanent Phone #: (____) _____
County of Origin in Oklahoma _____ (before Internship) Check if your origin state is NOT Oklahoma

DEMOGRAPHIC INFORMATION

Race/Ethnicity: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> American Indian/Alaskan Native
(Name of Tribe: _____) |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Other (Specify: _____) |
| <input type="checkbox"/> Black/African American | | |

***Primary Language**

Do you speak a language other than English at home?

- Yes, Spanish
 Yes, another language, please identify: _____
 No

If yes how well do you speak English?

- Very well
 Well
 Not well
 Not at all

Date of Birth: _____ (mm/dd/yyyy) **Gender:** Male or Female (circle one)

What is your personal relationship with disabilities?

Are you a.....(check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> person with a disability | <input type="checkbox"/> parent of a person with a special health care need |
| <input type="checkbox"/> person with a special health care need | <input type="checkbox"/> family member of a person with a disability |
| <input type="checkbox"/> parent of a person with a disability | <input type="checkbox"/> family member of a person w/a special health care need |
| <input type="checkbox"/> None – does not apply to me | |



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Prior to admission to the Oklahoma LEND Internship what was your

1. _____ Highest Academic Degree(s) Achieved? (AuD, DPT, MD, PhD, Parent, Consumer, etc...)

2. Position Setting at Admission? _____

This could be described as a Government Agency, Post-secondary Setting, Hospital, Non-Profit, For-Profit, Public Health/Title V, Schools or School System and UCEDD/LEND. For example, if you worked as a teacher in a school, then enter "school" as a response. "Upon admission" refers to the trainee's position at the time of admission or acceptance to the training program.

3. Position Title at Admission? _____

What was your primary position title upon admission to Oklahoma LEND? For example, if you were an elementary school teacher upon entering Oklahoma LEND then put "elementary school teacher" as the title. If not employed prior to admission, then put "not applicable" or "student", as appropriate.

CURRENT ACADEMIC STATUS

4. Current Academic Level: (NOW, *not* the highest degree earned)

Undergraduate Masters Doctoral Post Doctoral Non-Degree Other, specify: _____

5. _____ Current Degree Program: (NOW) (i.e., BA, MA, MSW, DDS, MD, PhD, DPH, EdD, etc.)

6. _____ Position in your degree Program: (fellow, resident, intern, grad student, etc)

7. Current Discipline: (Discipline of your current studies)

- | | |
|---|--|
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Family/Parent/Youth Advocacy | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Genetics/Genetic Counseling | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Medicine: <i>Developmental-Behavioral Pediatrics</i> | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Medicine: <i>Neurodevelopmental Disabilities</i> | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Medicine: <i>Pediatric</i> | <input type="checkbox"/> Self-Advocate |
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Nursing: Family/Pediatric Nurse Practitioner | <input type="checkbox"/> Speech Language Pathology |
| <input type="checkbox"/> Nursing: Other | <input type="checkbox"/> Other, _____ |

CURRENT EMPLOYMENT STATUS

8. Current place of employment: _____

9. Current job position/title: _____

10. Which of the following training curricula are you completing (independent of your funding sources)? MCH LEND ADD OSEP Pediatric Residency Other (specify: _____) N/A

SUPPORT TYPE

Check all categories to describe any program-related financial support you are currently receiving. (check all that apply)

11. Do you have MCH support? Yes No

12. Core Grant Funding

- MCH Core
- MCH Autism Supplement
- ADD
- OSEP

13. Other Funding

- Clinical Fees None/Not Applicable
- Academic Department
- Internship
- Fellowship/Scholarship
- Other

13. *If trainee receives MCH support list the amounts below * (i.e., stipend and/or or covered tuition/fees).

Stipend	\$ _____
Tuition & Fees	\$ _____
Total	\$ _____