

PROJECT REACH

Course Application Form

Name (as you would like it to appear on your certificate):	Last 4 digits of your SS#:
Agency:	Agency:
Address:	Work Phone:
City/State/ZIP:	Email Address:

COURSE TITLES	DATES	COURSE FEE
1.	1.	
2.	2.	
3.	3.	
4.	4.	
5.	5.	
6.	6.	

What is your field/profession? Please Choose One:

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV Prevention Professional | <input type="checkbox"/> MH Counselor | <input type="checkbox"/> Program Director/Administrator |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Psychologist | <input type="checkbox"/> Clinical Director/Supervisor |
| <input type="checkbox"/> Physician | <input type="checkbox"/> HIV Case Manager | <input type="checkbox"/> State Agency Representative |
| <input type="checkbox"/> Social Worker | <input type="checkbox"/> Substance Abuse Counselor | <input type="checkbox"/> Outreach Worker |
| <input type="checkbox"/> Other (Please Specify): _____ | | |

Are you on the RICPG?

- CPG Member Task Force Member Not a Member

I _____ (name) understand that:

Failure to attend the course will result in loss of deposit. _____ (Initial)

Attendance lists will be provided to Supervisors and RI Dept. of Health. _____ (Initial)

_____ (Participant Signature) _____ (Date)

_____ (Agency Supervisor) _____ (Date)

***Only forms received by mail will be accepted. Faxed or email forms are not accepted.
Deposit must accompany this form in order to be processed.***

***Please send completed registration to:
Project REACH c/o DATA of RI
102 Dupont Drive – Providence, RI 02907***

Office Use Only: Ch # _____ Amount _____ Completed _____
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