Montana Health Network Registration Form

Profile

Email Address: Verify Email Address:

First Name: Last Name:

Mailing Address: City: State: Zip:

Home Phone: Cell Phone:

Date of Birth:

Survey Questions

Course enrolling in Choose Only One

Why did you decide to enroll in this course?

What goals do you hope to reach by taking the training?

Are you retaking this course? Select One How did you hear about this course? Select One

Do you currently work in a healthcare setting? Select One If yes, what is your role? Select One

If applicable, please list your training credentials:

If applicable, please share your experience as a Community Health Worker (e.g. year' experience, job focus, etc):

Are you fluent in a second language? If so, please list (include English as a Second Language):

Demographic Information *(optional, this information is collected for grant documentation only)*

Race/Ethnicity Select one that best describes Gender Select One Highest Level of Previous Education Select One

In which county do you live?

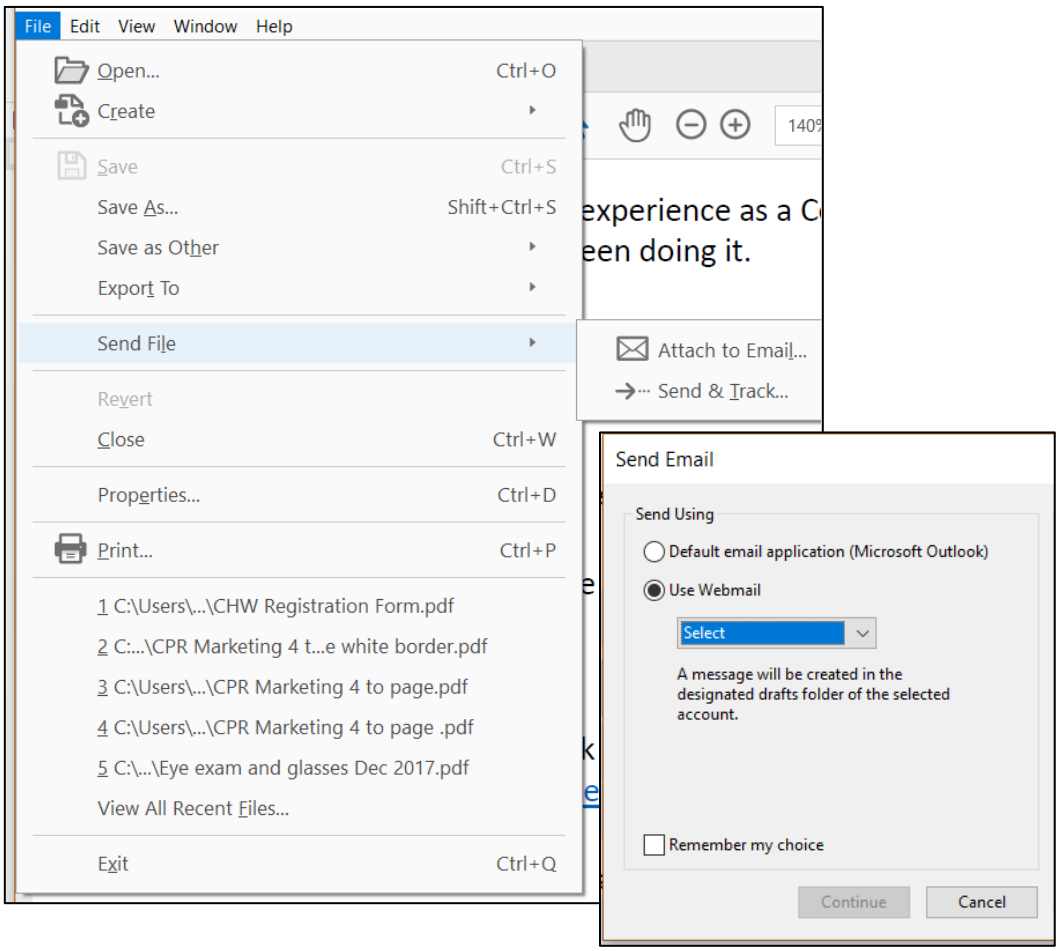
Employer/Facility Information

Host Site/Facility Name:

Site Instructor/Preceptor Name:

Instructor/Preceptor Email: Instructor/Preceptor Phone:

To submit this Form, please click on FILE>Send File>Attach to Email>Send Using (choose which email service you use and click on Continue) then copy and paste the following email address into recipient box:
registration@montanahealthnetwork.com



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