

HIV PREVENTION COUNSELOR CERTIFICATION COURSE REGISTRATION

State Form 53760 (R / 7-11) Indiana State Department of Health

INSTRUCTIONS:

The HIV Prevention Counselor Certification Course is a three and one-half (3.5) day skills based training for those persons who will provide HIV prevention counseling, testing, and referral (CTR); i.e., partner elicitation. The following guidelines for the course must be followed as conditions of attendance and potential certification for the course.

- 1. Prior to attending the course, applicants must complete an approved HIV101 course or completion of the ISDH proficiency test.
- 2. Attend the course in its entirety.
- 3. Actively participate and demonstrate skills learned during the course.
- 4. Each participant's skill level will be assessed. Reports and recommendations for each participant will be forwarded to his/her supervisor and to the HIV Prevention Program at the ISDH.
- 5. Return completed form to the HIV Prevention Training Manager:
 - a. by fax at (317) 233-7663; OR
 - b. mail to: HIV Prevention Training Manager

Indiana State Department of Health

2 North Meridian Street, Section 6C

Indianapolis, Indiana 46204

- 6. If accepted into the course, you will receive confirmation of enrollment approximately two (2) weeks prior to the course date selected. If not accepted for this course, you will be notified and informed as to the reason.
- 7. By signing this form you are agreeing that you have read the above information and understand the expectations and conditions.
- 8. For questions, call (317) 233-7051.

CTR Course Registration	
Full Name of Applicant:	
Agency/Organization:	
Address (number and street):	
Work Telephone Number: (Alternate Te	elephone Number: ()
Fax Number: () Work E-mail:	
Occupation/Position:	
Name of Supervisor:	
Supervisor's Telephone Number: ()	mail:
Training Dates Reason for taking the course:	
Prerequisite Documentation	
☐ Need the HIV Proficiency Test	
Attended approved HIV101 training within the past eighteen (18) months.	
Date attended approved HIV101 training:	
Location of approved HIV101 training:	(month/day/year)
Name of Instructor:	
Sign and Date	
Signature of Applicant:	Date: (month/day/year)
Signature of Supervisor:	(month/day/year) Date:

(month/day/year)