

ATTP PAPER APPLICATION

All ATTP correspondence during this course will be sent through your registered email below.

It's important for each applicant to use their own email address (either work or personal) and should be an email address which you frequently read. All confirmations, receipts and attendee details as well as the link to the online pre-requisite courses will be sent to the email provided and will be the email associated with the individual throughout the ATTP program.

TEAM APPLICATIONS:

All attendees must fill out an individual application, therefore **DO NOT WAIT** to gather your team members to apply. A checkbox is provided if you're attending with a team. All teams will be matched with their work affiliation in our system, even if you apply as an individual and later find others who plan to attend.

PAYMENT:

There is no payment due to apply to attend ATTP. Payment will be due after you've received a letter of acceptance to attend. A website link will be provided in your acceptance letter. Payment must be received prior to attending the onsite training. If extra time is needed due to your facility payment system, please contact us to work out a payment extension plan.

If you have questions, please contact Denise Beran at attp@parkinson.org or call 305-537-9938.

The email entered below MUST BE THE ATTENDEE'S email.

The email entered will be associated with the applicant's information.

1.

Required -Email:

*2. **Required** -How did you hear about the ATTP training the very first time? (Check the very first communication/information that provided awareness of this particular ATTP training.)

Please make 1 selection from the choices below.

- Parkinson's Foundation Email
- Parkinson's Foundation Website
- Parkinson's Foundation Staff contact
- Center of Excellence (COE)
- Referred by colleague who attended ATTP
- Other

3. Not Required -If you selected "other", please specify:

*4. **Required** -I am applying as: Practitioner (degreed professional)

- Administrator/Coordinator of a facility
- Fellow
- Student
- Other

*5. **Required** -Are you attending with a team of 3 or more from your facility? If you apply as an individual and later develop a team to attend or vice versa, our system will identify by the facility name and payment can be adjusted if already made. (Note: at least 2 must be from different disciplines for the team registration rate.)

- Yes
- No

*6. **Required** -What is your practitioner license number? (Please provide the national license if you have both state and national. If you are a student, type "student".)

Required -If you do not have a national license, was your state license issued in Florida? (Students reply as "no".)

- *7. Yes
- No

*8. **Required** -Current profession: (Students should list profession upon graduation)

- Medicine: Please specify specialty in next field
- Physician Assistant
- Nursing

- Nurse Practitioner
- Physical Therapy
- Occupational Therapy
- Speech-Language Pathology
- Social Work
- Other: Please specify in next field

9. Not Required -If you selected MEDICINE or OTHER, please specify here:

*10. **Required** -How many years experience in your profession? (Answer must be numeric. If student, put 0.)

Question - Required -Title:
*11. Ms.
 Mrs.
 Mr.
 Dr.

*12. **Required** -First Name:

13. Not Required -M.I.

*14. **Required** -Last Name:

*15. **Required** -Enter your credentials that should appear after your last name on the completion certificate: (ex: MS, CCC-SLP) Enter only the initials, not the name. If you're a student or a non-credentialed attendee, enter "0" and it will be auto-corrected for printing.

*16. **Required** -Cell phone or best phone number should we need to contact you with questions about your application:

Your work contact information will be listed on the ATTP attendee list for private distribution only among the attendees for future networking purposes.

Your home address will be kept confidential unless used as the company/facility address (for those who work in the field from home). All fields are required.

*If you're a student and **ARE NOT** in a work internship or field placement, enter the university name and your university mailing address. If you cannot receive mail at the university, use the*

word "none" in the street address and provide the remaining information (city/state/zip).

- *17. **Required** -Enter phone number to be used for the ATTP attendee networking list.
Do not enter dashes.

- *18. **Required** -Company / Facility Name (or if student, primary work internship/field placement setting if applicable, otherwise type "student"):

(Maximum response 255 chars, approx. 5 rows of text)

- *19. **Required** -Street Address (please include room / suite or floor number):

- *20. **Required** -City / Province

- *21. **Required** -State (2 letter abbreviation preferred unless from another country):

- *22. **Required** -Zip/postal code:

- *23. **Required** -Country (If USA, enter as USA):

- *24. **Required** -Work/Internship title (if student and not working, enter "none"):

- *25. **Required** -Home street address:

- *26. **Required** -City:

- *27. **Required** -State (2 letter abbreviation preferred unless from another country):

- *28. **Required** -Zip/postal code:

- *29. **Required** -Country (If USA, enter as USA):

- *30. **Required** -Your PRIMARY work setting / internship / field placement (**check all that apply**):

- Medical or Rehabilitation facility
- University facility
- Inpatient unit

- Outpatient clinic/center
- Private practice group
- Private practice individual
- Home Health Care
- Community based practice
- Assisted Living Facility
- Long term care - skilled nursing facility
- Long term care - assisted living facility
- Other

Not Required -If you selected "other", please specify:

31.

Please answer the following questions pertaining only to your CURRENT profession for which you are applying to attend ATTP:

*32. **Required** -Highest degree obtained (or current field of study):

*33. **Required** -Major or area of specialty:

Please make between 1 and 3 selections from the choices below.

- MD
- PA
- RN
- NP
- PT
- OT
- SLP
- SW
- Other

34. **Required** -If you selected OTHER, please specify:

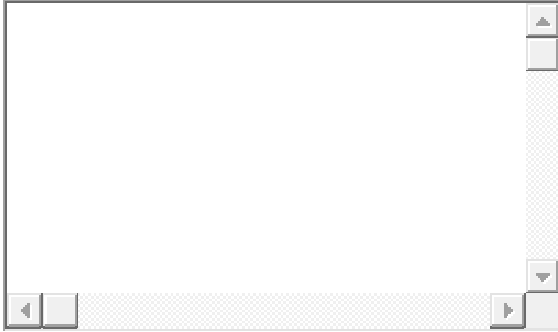
*35. **Required** -Highest level of degree/diploma obtained (or, if student, what degree is expected upon upcoming graduation):

- Associate
- Bachelors
- Masters
- Doctorate
- MD
- Other

36. Not Required -If you selected OTHER, please specify here:

Required -Brief description of your work or practicum experience (include any experience with older adults or persons with Parkinson's disease or care partners): Max 150 words.

*37.



Required -What are YOUR primary educational objectives for this training? Max 150 words

*38.



Required -Are you currently working with rural populations?

- *39. Yes
 No

Required -Do you have experience in working on an interdisciplinary team?

- *40. Yes
 No

*41. **Required**- Have you ever worked at a Parkinson's Foundation Center of Excellence (COE)?

- Yes
 No

Required -Are you currently working on an interdisciplinary team?

- *42. Yes
 No

43. **Required** -If yes, is this a movement disorders-specific interdisciplinary team? (If no, please skip to question 45.)

- Yes
- No

44. Not Required -How many years has your current interdisciplinary team been functioning?
(If less than 1 year, please indicate <1.)

45.

Not Required -How long have you been on this team?

Please respond with a number or use the arrow character with a number if less than one year
(i.g.: <1).

Skip this question if you are not on a team.

The following answers are important in helping us with future program planning.

Using the scale below each question, please rate how IMPORTANT each of the following topics or educational goals are to you.

Required -Understanding PD symptoms:

- *46. 0 = not important
 1 = somewhat important
 2 = moderately important
 3 = very important

Required -Learning about the latest medical or surgical treatment:

- *47. 0 = not important
 1 = somewhat important
 2 = moderately important
 3 = very important

Required -Advances in my unique discipline:

- *48. 0 = not important
 1 = somewhat important
 2 = moderately important
 3 = very important

Required -Learning about other discipline-related therapies:

- *49. 0 = not important
 1 = somewhat important

- 2 = moderately important
- 3 = very important

Required -Wellness-based approaches to care:

- *50. 0 = not important
- 1 = somewhat important
 - 2 = moderately important
 - 3 = very important

Required -Interdisciplinary team building:

- *51. 0 = not important
- 1 = somewhat important
 - 2 = moderately important
 - 3 = very important

Required -Development/management of a clinical team:

- *52. 0 = not important
- 1 = somewhat important
 - 2 = moderately important
 - 3 = very important

Required -Clinical communication strategies:

- *53. 0 = not important
- 1 = somewhat important
 - 2 = moderately important
 - 3 = very important

Required -Effective business models (reimbursement; ICD-10 coding for PD):

- *54. 0 = not important
- 1 = somewhat important
 - 2 = moderately important
 - 3 = very important

*In the last calendar year, **what percent of your time was spent in:** (if student and not in practicum, put "0")*

*55. **Required** -Direct patient care:

*56. **Required** -Management / admin duties:

*57. **Required** -Research:

For the next set of questions please report UNDUPLICATED clients. In other words, count each PD client only once in the calendar year; do not count repeated visits by the same person. (Students not in practicum, put "0".)

*58. **Required** -In the last calendar year, **what percent** of your annual caseload was with Parkinson's patients, caregivers or families?

*59.

Required -In the last calendar year, how many people with Parkinson's did you see?

*60. **Required** -In the last calendar year, how many caregivers of people with Parkinson's did you see?

*61. **Required** -In the last calendar year, how many newly diagnosed Parkinson's patients did you see?

Please answer the next 2 questions on a scale of 1-10.

1 = not at all confident; 10 = extremely confident

*62. **Required** -How confident are you now in working with or treating a person with Parkinson's disease?

- 1 (Not at all confident)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Extremely confident)

*63. **Required** -How confident are you now in working with the care partner of a person with Parkinson's disease?

- 1 (Not at all confident)
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 (Extremely confident)

*64. **Required** -Have you ever attended an ATTP course presented by the Parkinson's Foundation (or previously National Parkinson's Foundation)?

- Yes
- No

*65. ***Required** -If yes, what city and what year did you attend?



66. **Not Required** -Is there anything else you want to add about what you hope to learn from this training? (Max 150 words)



*67. **Required** -RSVP for THURSDAY EVENING NETWORKING DINNER: A complimentary networking reception and plated dinner will be hosted for the ATTP attendees by Parkinson's

Canada. This is a great opportunity to network with other attendees and ATTP faculty. Let us know if you plan to attend by your RSVP response below:

- Yes
- No

- *68. **Required** -Dietary concerns: Please list dietary requirements below and we will request the hotel to provide as best they can. (vegetarian / gluten-free / nut allergy / fish allergy / shellfish allergy or other). If none, please enter the word none.

*Please provide emergency contact information of someone who **will NOT be attending or traveling** with you to ATTP.*

Our organization respects your privacy and this information would only be accessed in case of an emergency. (And of course, we hope to never have a reason to access this data!)

- *69. **Required** -Emergency contact name:

- *70. **Required** -Emergency contact number (no dashes)

71. Question - Required -As a participant in ATTP, the International Parkinson's Movement Disorder Society (MDS) will offer you one year of complimentary associate membership. This grants you access to the MDS membership list, as well as their online educational materials (a \$100 value) and reduced rates for future MDS programs. Would you like to opt into this free membership?

- Yes
- No

- *72. Question - Required -For our room block planning purposes, please confirm if you plan to stay at the conference site hotel. The room block reservation code for the ATTP group rate will be provided in your letter of acceptance. Attendees are responsible for arranging their hotel and travel accommodations.

- Yes
- No

During the live event, the Parkinson's Foundation staff will occasionally take pictures or small snips of video or quotes solely for the purposes of Parkinson's education, future ATTP programming and fundraising for our mission for better care for those living with Parkinson's disease. To remain in compliance with such permissions, please provide your acknowledgement below:

*73. **Required** -I hereby give the Parkinson's Foundation permission to use my name/story/photograph/video in materials produced by the Foundation for the purposes of public education and fundraising for the Parkinson's Foundation mission.

Yes

No