**Trainee Survey FY 2025 - LEAH Trainees**

\* Response Required

**Contact / Background Information**

|  |  |
| --- | --- |
| **\*First Name**: |  |
| **Middle Name:** |  |
| **\*Last Name** |  |
|  **Previous/Maiden Name**:(if applicable) |  |
| **Current Address** (where you would like to be contacted)**\*Address 1**: |  |
| **Address 2:** |  |
| **\*City** |  |
| **\*State** |  |
| **\*Zip** |  |
| **Phone** (999-999-9999):  |  |
| **Primary Email**:  |  |
| **Secondary Email**: |  |

**What is the name of your current place of employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is the name of your current job position/title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Permanent* Contact Information** (someone at a different address who will know how to contact you in the future, e.g., parents)

|  |  |  |
| --- | --- | --- |
| **\*Name of Contact**: |  |  |
|  **Relationship**: |  |  |
| **\*Address 1**: |  |  |
| **Address 2:** |  |  |
| **\*City** |  |  |
| **\*State** |  |  |
| **\*Zip** |  |  |
| **Phone** (999-999-9999):  |  |  |  |  |
|  **\*Email Address**:  |  |  |  |

**\*Are you a first-generation college student?**

* Yes
* No
* Choose not to disclose/unrecorded

**\*Primary discipline while participating in the Training Program:**

* Applied Behavioral Analysis
* Audiology
* Biological Sciences
* Community Health Worker
* Community Member/Person with Lived Experience
* Dentistry-Other
* Dentistry – Pediatric
* Dietetics
* Disability Studies
* Doula
* Education: Administration
* Education: Early Intervention/Early Childhood
* Education: General Education
* Epidemiology
* Education/Special Education
* Family/ Parents/ Youth Advocacy
* Family Studies
* Family Member/Community Member
* Genetics/Genetic Counseling
* Gerontology
* Health Administration
* Human Development/Child Development
* Interdisciplinary
* Law
* Liberal Arts & Science, Humanities, and General Studies
* Medicine-General
* Medicine-Adolescent Medicine
* Medicine-Adult Providers
* Medicine-Developmental-Behavioral Pediatrics
* Nursing-General
* Medicine-Neurodevelopmental Disabilities
* Medicine – Other
* Medicine-Pediatric Pulmonology
* Medicine-Pediatrics
* Medicine-Sleep
* Mental and Behavioral Health
* Nursing-Family/Pediatric Nurse Practitioner
* Nursing-General
* Nursing-Midwife
* Nursing – Other
* Nutrition
* Occupational Therapy
* Pastoral
* Person with a disability or special health care need
* Physical Therapy
* Pharmacy
* Psychiatry
* Psychology
* Public Administration
* Public Health
* Rehabilitation
* Respiratory Therapy
* Social Work
* Speech-Language Pathology
* Other - Please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender:**

* Male
* Female

**Other Gender Description** (if the option “Other” is selected above): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***\*Race***: (select one)

* **American Indian or Alaska Native** refer to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
	+ Tribe: \_\_\_\_\_\_\_\_\_\_
* **Asian** refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g. Asian Indian).
* **Black or African American** refers to people having origins in any of the Black racial groups of Africa.
* **Native Hawaiian or Other Pacific Islander** refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
* **White** refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa.
* **More than one** race includes individuals who identify with two or more racial designations.
* **Unrecorded** is included for individuals who are unable to identify with the categories.

***\*Ethnicity***: (select one)

*Hispanic* is an ethnic category for people whose origins are in the Spanish-speaking countries of Latin America or who identify with a Spanish-speaking culture. Individuals who are Hispanic may be of any race.

* **Hispanic**
* **Non-Hispanic**
* **Unrecorded** is included for individuals who are unable to identify with the categories

**\*Training Completion Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_** (mm/yyyy)

**Trainee Survey**

**Please answer the following questions as thoroughly as possible. When you have filled out the entire survey, return it to your Center/Program.**

**\*1. Does your current work relate to Maternal and Child Health (MCH) populations (i.e. women, infants and children, adolescents, and their families including fathers and children or young adults with special health care needs)**

* Women or people who have given birth
* Infants
* Children
* Adolescents and young adults
* Fathers or other caregivers
* Children and youth with special health care needs, including children with autism spectrum disorder or other developmental disabilities
* None or unknown

**2. Does your current work relate to individuals with disabilities?**

* **Yes**
* **No**

**\*3. Does your current work relate to populations that are underserved or have been marginalized? (select all that apply)**

* Racially/ethnically diverse populations
* Indigenous populations
* LGBTQ+ populations
* Rural populations
* Children and youth with special health care needs
* People with disabilities
* People living in poverty
* People experiencing homelessness
* Military veterans
* None or unknown

**\*4. What is the trainee’s current employment setting?**

* Student
* Elementary or secondary school or school system
* Undergraduate or graduate-level institution
* State health department, including Title V
* Other government agency (e.g. Federal, state, or local)
* Clinical health care setting (including hospitals, health centers, and clinics)
* Community-based organization or non-profit
* Other private sector or organization
* Not currently working or retired
* Other

**\*5. Zip code of employment setting selected:** \_\_\_\_\_\_\_\_\_\_

**Leadership Activities**

 **\*6. Have you done any of the following activities since completing your training program?**

* **Academic**: Disseminated information on MCH issues (e.g., peer-reviews publications, key presentations, training manuals, issue briefs, best practices documents, standards of care); Conducted research or quality improvement on MCH issues; Provided consultation or technical assistance in MCH areas; Taught/mentored in MCH discipline or other MCH related field; Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process); Procured grant and other funding in MCH areas; Conducted strategic planning or program evaluation
* **Clinical**: Participated as a group leader, initiator, key contributor or in a position of influence/authority on any other the following: committees of state, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.; Served in a leadership position in a clinical setting (e.g., director, senior therapist, team leader); Taught/mentored in MCH discipline or other MCH related field; Conducted research or quality improvement on MCH issues; Disseminated information on MCH issues (e.g., peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care); Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
* **Public Health**: Provided consultation, technical assistance, or training in MCH areas; Procured gran or other funding in MCH areas; Conducted strategic planning or program evaluation; Conducted research or quality improvement on MCH issues; Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
* **Public Policy & Advocacy**: Participated in public policy development activities at local, state, or national levels (e.g., participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation, provided testimony, educated legislators); Participated on any of the following as a group leader, initiator, or key contributor: committees of state, national, or local organizations; task forces; community boards; research societies; professional societies; etc.; Presented or disseminated information on MCH public policy issues to a legislative body, key decision makers, foundations, or the general public (e.g., peer-reviewed publications, key presentations, training manuals, issue briefs, best practice documents, standards of care, commentaries, and chapters)
* None or Unknown

\***7.** **Have you participated or led any of the following interdisciplinary/interprofessional activities since completing your training program? (select all that apply)**

* Sought input to information from other professions, disciplines, people with lived experience, or self-advocated to address a need in their work
* Provided input or information to other professions or disciplines
* Developed a shared vision, roles and responsibilities across disciplines
* Utilized shared vision, roles or responsibilities to develop a coordinated, prioritized plan across disciplines to address a need in their work
* Established decision-making procedures in an interdisciplinary group
* Collaborated with various disciplines across agencies/entities
* Advanced policies & programs that promote collaboration with other disciplines or professions
* Engaged in clinical practice working in collaboration across disciplines and with the patient
* None or unknown

**8. Please describe professional achievement(s) that you would attribute to the training program or anything else you’d like us to know about your career.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Evaluation of Training Program**

**9. I would recommend the training program to others.**

\_\_ 3 \_\_ 2 \_\_ 1 \_\_ 0 \_\_

(completely agree) (mostly agree) (partially agree) (disagree) no response

**10. Thinking about the professional skills needed by health care professionals in your own field, what suggestions for changing training curriculum would you recommend for our Training Program?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Confidentiality Statement**

Thank you for agreeing to provide information that will enable your training program to track your training experience and follow up with you after the completion of your federally-funded training program. Your input is critical to our own improvement efforts and our compliance with Federal reporting requirements.

Please know that your participation in providing information is entirely voluntary. The information you provide will only be used for monitoring and improvement of the training program. Please also be assured that we take the confidentiality of your personal information very seriously. None of the information that you provide will be used to individually identify you to any outside agency, such as the Maternal Child Health Bureau (MCHB) or Administration on Intellectual and Developmental Disabilities (OIDD). Any information supplied to any other federal agencies or public will be done on an aggregate basis in such a way as to preclude the ability to identify any individual trainee.

If you have any questions, concerns, or need the survey in an alternate format, please contact the Director of the Center from which you received your training or email NIRS.

We very much appreciate your time and assistance in helping to document outcomes of the Training Program. We look forward to learning about your academic and professional development.