**Lillian Rivera RN, MSN, PhD Administrator**
**Florida Department of Health in Miami Dade County**

# AIDS-501

## Pre-Registration

Please check below the title that applies to you:

☐ Counselor ☐ Case Manager

**TRAINING DATES REQUESTED:** _____
Month / Date / Year

In order to ensure that each participant receive adequate mentorship for his/her Practicum, it is imperative for our office to have the following information for our records:

**TESTING SITE INFORMATION:**

_____ _____
Name of Agency Site Number

**PARTICIPANT INFORMATION:**

_____ _____
Print Name Signature

E-Mail Address: _____ Phone Number _____
(Required) (Required)

**Name of participant's Supervisor:**

_____ _____
Print Name Signature

**Name of Experienced Counselor if different from Supervisor:**

_____ _____
Print Name Signature

**Scan and send this form and AIDS 500 online Certificate of Completion to the attention of:**
**Lisa Quammie-John: Lisa.Quammie-John@flhealth.gov**
For more information, you may contact **Lisa Quammie-John** at: **305-643-7420 ext. 21325.**