

## POTENTIAL PARTICIPANT QUESTIONNAIRE

*This questionnaire is to be completed by each potential participant. Please note your participation in the Prolonged Exposure training is voluntary.*

<b>Full Name</b>			
<b>Title</b>			
<b>Email</b>			
<b>Education Degree(s) and Year(s)</b>			
<b>Professional Discipline</b>			
<b>PA License(s) Held</b>			
<b>PA Credential(s) Held</b>			
<b>Languages Spoken Besides English</b>			
<b>Agency Name</b>			
<b>Agency Address</b>			
<b>Employment Status</b>	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Fee For Service
<b>Clinical Time Breakdown (%)</b>	Individual Treatment	Group Treatment	Family-Focused Treatment
<b>Are you trained in other EBPs?</b>	<input type="checkbox"/> Yes		<input type="checkbox"/> No
<b>If yes, which EBTs?</b>			

*Please describe your interest in learning about Prolonged Exposure training.*

*Please describe your efforts to provide culturally responsive and anti-racist care.*