SURNAME: **FIRST NAME:** **OTHERS:**

GENDER: **MALE** **FEMALE** **DATE OF BIRTH**

TITLE **PROF** **DR** **Mr.** **Mrs.** **Ms**

PROFESSION [check one]:

DOCTOR SPECIALIST **DOCTOR GENERALIST** **PHARMACIST** **NURSE** **OTHERS**

If specialist, please select speciality

CARDIOLOGY **DERMATOLOGY** **FAMILY MEDICINE** **INFECTIOUS DISEASES**

OBGYN **PAEDIATRICS** **INTERNAL MEDICINE** **PSYCHIATRY**

PROFESSIONAL ASSOCIATION PRACTICE NUMBER

NUMBER OF YEARS IN CARE OF PLHIV

CURRENT AFFILIATION (tick as appropriate):

HOSPITAL **NGO** **GOVERNMENT (non clinical)** **PRIVATE PRACTICE (clinical)** **UNIVERISITY**

PRIVATE PRACTICE (non-clinical)

INSTITUTION OF CURRENT PRACTICE:

ADDRESS OF INSTITUTION:

CITY: **STATE:** **COUNTRY:**

PROFESSIONAL ACTIVITIES:

ADMINISTRATION ☐ **PATIENT CARE** ☐ **PROGRAM MANAGEMENT** ☐ **RESEARCH** ☐ **ADVOCACY** ☐

TEACHING/EDUCATION ☐ **SALES/MARKETING** ☐ **OTHERS**

CONTACT INFORMATION:

EMAIL:

TELEPHONE1:

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