

## Counselor ID Request Form

All Counselor ID requests are completed in the order in which they are received. Please allow up to a week for processing.

\* Denotes required fields.

\* Requested by: (First Name, Last Name) \_\_\_\_\_

\* Position within the agency (volunteer, staff person...etc) \_\_\_\_\_

\* Facility Name and Unique Agency ID Number: \_\_\_\_\_

\* Completion date of the: HIV/STD Basic Training Course #1 Revised 2008 (Web-based) (1007721): \_\_\_\_\_

\* Completion date of the Behavior Change Course "Part I" (1063103)  
\_\_\_\_\_

\* Completion date of the Behavior Change Course "Part II" \_\_\_\_\_

\* Phone Number: \_\_\_\_\_

\* Fax Number: \_\_\_\_\_

\* Email: \_\_\_\_\_

\* **Note** - In order to submit a request for these records online, a FAX number and email address are necessary

Comments or Questions:

\_\_\_\_\_  
\_\_\_\_\_

\* **Note** - At least one selection below is required before submittal.

\* Select the ones that apply to you: I administer HIV Testing through.

- Rapid Tests
- Venipuncture

**Questions: Contact Camille Cushinberry at (785) 296-7716, fax (785) 559-4229 or email [ccushinberry@kdheks.gov](mailto:ccushinberry@kdheks.gov).**

