# NIRS Activity Data Form

Name:_________________________________ Date:__________________________________

| 1) Program Type: | ☐ LEND | ☐ UCEDD |

| 2) Fiscal Year: |

| 3) Title of Activity: |

| 4) Date of Activity: |

| 5) Core Function (Select only one of the major core function categories [in ovals]. Multiple subcategories [in boxes] may be selected.) |

- ☐ TRAINING
  - ☐ Pre-Service Preparation
  - ☐ Continuing Education
  - ☐ Community Training

- ☐ RESEARCH AND EVALUATION
  - ☐ Please check if this activity was a measure of progress towards grant goals. If yes, check all that apply below:
    - ☐ Collaboration
    - ☐ Consumer Satisfaction
    - ☐ Improvement

- ☐ DIRECT SERVICE
  - ☐ Direct Clinical Services (Please fill out questions below)
    a) Name of clinic:________________________
    b) Number of clients seen: #______
    c) Ethnicity of clients seen (Supply number for all that apply)
      - #______White
      - #______Black or African-American
      - #______American Indian and Alaska Native Tribe:
      - #______Asian (Includes Asian, Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and other Asian)
      - #______Native Hawaiian and other Pacific Islander
      - #______Hispanic or Latino (Includes Mexican, Puerto Rican, Cuban and other Hispanic or Latino)
      - #______Multiracial
      - #______Other (Please specify):
    d) Age of Clients seen (Supply number for all that apply)
      - #______0-2 #______18-21
      - #______3-5 #______22-54
      - #______6-11 #______55+
      - #______12-17

- ☐ TECHNICAL ASSISTANCE

- ☐ INFORMATION DEVELOPMENT /DISSEMINATION
  - ☐ Product Dissemination (MUST FILL OUT A PRODUCT FORM)
6) Type of Action (Select one option. If either “Direct Clinical Services” or “Community-Based Client Consults” is selected then “capacity-building” should be indicated for the type of action.)

- Advocacy
- Capacity Building
- Systems Change

7) Area of Emphasis (Check all that apply. If either “Direct Clinical Services” or “Community-Based Client Consults” is selected then “health-related activities” should be indicated as one of the areas of emphasis.)

- Quality Assurance
- Health-Related Activities
- Transportation-Related Activities
- Education and Early Intervention
- Employment-Related Activities
- Recreation-Related Activities
- Child Care-Related Activities
- Housing-Related Activities
- Quality of Life
- Other (Please Specify):

8) Types and Number of Participants (Supply Number for all that apply)

- #______Classroom Students
  - a) Discipline of Class (Check One)
    - Audiology
    - Dental/Pediatric Dentistry
    - Education: Early Intervention Education
    - Education: Other Education
    - General Medicine
    - Health Administration Development
    - Interdisciplinary Nursing
    - Nutrition Occupational Therapy
    - Pediatrics Physical Therapy
    - Psychiatry Psychology-Clinical
    - Psychology-General Speech-Language Pathology
    - Other/Unknown: (Please specify):

- #______Professionals and Para-Professionals
- #______Family Members/Caregivers
- #______Persons with DD/Children with Special Health Care Needs
- #______General Public
- #______Other Participants (Please Specify):

- Not Applicable

9) Collaborating Agency(ies) (Check all that apply and supply the name of the agency in the space provided)

- State Title V Agency (Please specify):
- Other Maternal Child Health Bureau Program (Please specify):
- Other Health-Related Program (Please specify):
- Developmental Disabilities Council (Please specify):
- Protection and Advocacy Organization (Please specify):
- UCEDD (Please specify):
- Other (Please specify):
- Not Applicable

10) a) Primary Affiliated Project (Please specify):
    b) Secondary Affiliated Project (Please specify):

- No Project Affiliation

11) Duration (Report to the nearest full hour the duration of your activity):

12) Primary Age Group Affected by Activity (Indicate the age group of the individuals affected by the activity. For example if conducting a training to early interventionists, “Infant & Toddler” should be selected. Choose only one age group.)

- Prenatal
- Infant & Toddler (0-2)
- Preschool (3-5)
- School Age (6-18)
- School Age & Young Adult
- Young Adult (19-22)
- Older Adult (50-59)
- Senior Adult (60+)
- All Adults (23+)
- All Ages

13) Did this activity include technical assistance regarding assistive technology?

- Yes
- No

14) Brief Description of Activity

- ____________________________
- ____________________________
- ____________________________
- ____________________________
- ____________________________
- ____________________________