

CPWR Student Registration Form

(Complete both sides of form)

Course Information:

| | | | |
|--------------|----------|-------|--------|
| Course Type: | Date(s): | City: | State: |
| Course ID #: | | | |

Student Information:

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|--|--|--|--|
| Name: | | | |
| Street Address: | | | |
| City: | | State: | Zip: |
| Phone: | | Email: | |
| Would you like to receive CPWR's monthly newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | | Birth Date (mm/dd/yy): ____ / ____ / ____ | |
| Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other: _____ | | | |
| The last <u>3</u> digits of your Social Security Number: <u> X </u> <u> X </u> <u> X </u> - <u> X </u> <u> X </u> - <u> X </u> _____ | | | |
| Employer Name: | | Are You a/an: (check one) | |
| City: | | Pre-Apprentice <input type="checkbox"/> Apprentice <input type="checkbox"/> | |
| State: | | Journey worker <input type="checkbox"/> Instructor <input type="checkbox"/> | |
| Other: _____ | | | |
| Are You A Union Member? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, please indicate your craft/trade and local union/district council below)</i> | | | |
| <input type="checkbox"/> Boilermakers | <input type="checkbox"/> BAC/Bricklayers | <input type="checkbox"/> UBC/Carpenters | <input type="checkbox"/> Electrical Workers |
| <input type="checkbox"/> Insulators/Asbestos Workers | <input type="checkbox"/> Ironworkers | <input type="checkbox"/> Laborers | <input type="checkbox"/> Operating Engineers |
| <input type="checkbox"/> IUPAT/Painters | <input type="checkbox"/> Plasterers/Cement Masons | <input type="checkbox"/> Roofers/Waterproofers | <input type="checkbox"/> Sheet Metal Workers |
| <input type="checkbox"/> United Association | <input type="checkbox"/> Other (please specify): _____ | | |
| Local Union/District Council: | | | |
| What resources do you most commonly turn to for the latest health and safety information? <i>(check (✓) up to 3)</i> | | | |
| <input type="checkbox"/> Union | <input type="checkbox"/> Trade Association | <input type="checkbox"/> Government Agency <i>(please circle: OSHA, NIOSH, NIEHS, Other)</i> | <input type="checkbox"/> News Media |
| <input type="checkbox"/> CPWR Resources | <input type="checkbox"/> Internet Search | <input type="checkbox"/> Other (please specify): _____ | |

For Trainer/Office Use Only:

| | | | |
|-----------------|------------------|--------------------------------|-----------------------|
| Pre-Test: _____ | Post-Test: _____ | Hands-on Training Score: _____ | Combined Score: _____ |
|-----------------|------------------|--------------------------------|-----------------------|

Question 1:

| | | | | | |
|--|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|
| In the last 5 years, have you done work that required you to be certified/trained for: | | | | | |
| Hazardous waste | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Confined Space Entry | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ICRA (Infection Control) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asbestos | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fall Protection | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lead | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Disaster Site Worker | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| OSHA 10-hour Construction | <input type="checkbox"/> Yes | <input type="checkbox"/> No | OSHA 10-hour General Industry | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| OSHA 30-hour Construction | <input type="checkbox"/> Yes | <input type="checkbox"/> No | OSHA 30-hour General Industry | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Question 2:

| | | | |
|---|---|--|---|
| In the last 2 years, have you come across any of the following safety/health hazards on the job site? | | | |
| Please check all that you have been exposed to at work: | | | |
| <input type="checkbox"/> Contaminated Soil | <input type="checkbox"/> Solvents | <input type="checkbox"/> Asbestos | <input type="checkbox"/> Lead |
| <input type="checkbox"/> Contaminated Water | <input type="checkbox"/> Confined Spaces | <input type="checkbox"/> Nanoparticles | <input type="checkbox"/> Silica Dust |
| <input type="checkbox"/> Beryllium | <input type="checkbox"/> Loud Noise | <input type="checkbox"/> Welding fumes | <input type="checkbox"/> Mold |
| <input type="checkbox"/> Lifting greater than 50 lbs. | <input type="checkbox"/> Ionizing Radiation | <input type="checkbox"/> Vibration | |
| <input type="checkbox"/> RF Radiation (cell antennas) | <input type="checkbox"/> Extreme Heat/Cold | | |
| <input type="checkbox"/> Other hazards (<i>specify</i>): | | | |
| Please check the personal protective equipment provided to you: | | | |
| <input type="checkbox"/> Respirator with filters | <input type="checkbox"/> Respirator with air tank or hose | <input type="checkbox"/> Chemical resistant gloves | <input type="checkbox"/> Chemical resistant boots |
| <input type="checkbox"/> Chemical resistant suit | <input type="checkbox"/> Hearing Protection | <input type="checkbox"/> Fall Protection | <input type="checkbox"/> Dust mask |
| <input type="checkbox"/> Other (<i>specify</i>): | _____ | | |
| <input type="checkbox"/> No PPE was provided | For which hazard above did you not get PPE? | | |

Question 3:

| | | | |
|---|--|------------------------------|-----------------------------|
| Are you taking this training because you need this certificate/training to go to work? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <ul style="list-style-type: none">If Yes, please list the job and employer that requires you to be certified/trained in this topic. | | | |
| Job Site Name: _____ | | | |
| Employer: _____ | | | |
| Job Location (City, State): _____ | | | |

Question 4:

| | | | |
|---|--|------------------------------|-----------------------------|
| Have you ever worked at a Department of Energy site? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <ul style="list-style-type: none">If Yes, which site? _____ | | | |