Instructions
The information you provide on this form is indicative of your participation in this activity. Your responses will only be shared with presenters and planning committee members in aggregate format. Upon completion of the form, please submit the form by email to ProjectECHO@med.unr.edu or fax it to (775) 327-5112. Only those individuals who complete and return this form will receive credit.

Name:

Address:

City: State: Zip:

Telephone: License Number: Email:

1. In which setting do you work?
   - Federally Qualified Health Center (FQHC)
   - Office-based Opioid Treatment (OBOT)
   - Opioid Treatment Program (OTP)
   - Certified Community Behavioral Health Clinics (CCBHC)
   - Hospital/Emergency Room
   - Rural Health Clinic
   - Other (please describe):

2. Are you currently Data-2000 buprenorphine waivered? Yes No If no, reason:

3. If you plan to make changes in your practice, please identify any barriers that you perceive in implementing these changes (select all that apply).
   - Lack of time to assess patients
   - Lack of time to counsel patients
   - Insurance/Reimbursement issues
   - Patient compliance issues
   - Other (please describe):
   - Lack of consensus on professional guidelines
   - Lack of knowledge to do so
   - Lack of management/clinic support
   - None – I do not plan to make any changes
   - None – I am able and plan to make changes

4. Was the material presented in a manner that was free from commercial bias? Yes No If no, please explain:

5. Please list topics of future interest and additional comment regarding teleECHO clinics: