

Indiana 2022 Physician Assistant License Renewal Information Fields

1. Sex
DROP DOWN
 - a. Female
 - b. Male

2. Are you of Hispanic, Latina/o, or Spanish origin?
RADIO BUTTONS
 - a. Yes
 - b. No

3. What is your race? Mark one or more boxes.
MULTI CHECK BOX
 - a. American Indian or Alaska Native
 - b. Asian
 - c. Black or African American
 - d. Native Hawaiian/Pacific Islander
 - e. White
 - f. Some Other Race

4. What type of physician assistant degree/credential qualified you for your first U.S. physician assistant license? DROP-DOWN LIST OR RADIO BUTTONS
 - a. Certificate/diploma
 - b. Associate degree
 - c. Bachelor's degree
 - d. Master's degree
 - e. Doctorate degree
 - f. Military training certification
 - g. Other

5. Where did you complete the physician assistant degree/credential that qualified you for your first U.S. physician assistant license?
DROP DOWN LIST
 - a. Indiana
 - b. Michigan
 - c. Illinois
 - d. Kentucky
 - e. Ohio
 - f. Another State (not listed)
 - g. Another Country (not U.S.)

6. Do you use telehealth to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; "telehealth" means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: (1) secure videoconferencing; (2) interactive audio-using store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location)?
RADIO BUTTON
 - a. Yes
 - b. No

7. If you have completed a Physician Assistant Post-Graduate Training program, in which specialty was your training? If you have not completed a Physician Assistant Post-Graduate Training program, please select "No Post-Graduate Training Completed."

DROP DOWN

- a. No Post-Graduate Training Completed
- b. Acute Care Medicine
- c. Cardiology
- d. Cardiothoracic
- e. Critical Care/Trauma
- f. Emergency Medicine
- g. Family Medicine
- h. Hematology/Oncology
- i. Hospitalist
- j. Internal Medicine
- k. Neonatology
- l. Neurosurgery
- m. OB-GYN
- n. Orthopedic Surgery
- o. Otolaryngology
- p. Pediatrics
- q. Psychiatry
- r. Surgery
- s. Urgent Care
- t. Urology
- u. Other

8. What is your employment status?

DROP DOWN

- a. Actively working in a position that requires a physician assistant license
- b. Actively working in a physician assistant related field that does not require a physician assistant license
- c. Actively working in a non-physician assistant field that does not require a physician assistant license
- d. Not currently working, disabled
- e. Not currently working, seeking work in a position that requires a physician assistant license
- f. Not currently working, seeking work in a position that does not require a physician assistant license
- g. Student
- h. Leave of absence or Sabbatical
- i. Retired

9. What are your employment plans for the next 12 months?

RADIO BUTTONS

- a. Increase hours in the physician assistant field
- b. Decrease hours in the physician assistant field
- c. Leave employment in the field of physician assistant
- d. No planned change

10. Is your primary practice located in the state of Indiana (*the position in which you spend the majority of your time*)?

RADIO BUTTON

- a. Not applicable
- b. Yes

11. If located in Indiana, what is the county of your primary practice location? If this does not apply, please indicate "N/A"

_____ (free text)

12. If located in Indiana, what is the zip code of your primary practice location? If this does not apply, please indicate "N/A"

_____ (free text)

13. Estimate the average number of hours per week spent at your primary practice location. *If this does not apply, please select "not applicable."*

DROP-DOWN LIST

- a. Not applicable
- b. 0 hours per week
- c. 1 – 4 hours per week
- d. 5 – 8 hours per week
- e. 9 – 12 hours per week
- f. 13 – 16 hours per week
- g. 17 – 20 hours per week
- h. 21 – 24 hours per week
- i. 25 – 28 hours per week
- j. 29 – 32 hours per week
- k. 33 – 36 hours per week
- l. 37 – 40 hours per week
- m. 41 or more hours per week

14. Estimate the average number of hours per week spent in direct patient care at your primary practice location. *If this does not apply, please select "not applicable."*

DROP-DOWN LIST OR RADIO BUTTONS

- a. Not applicable
- b. 0 hours per week
- c. 1 – 4 hours per week
- d. 5 – 8 hours per week
- e. 9 – 12 hours per week
- f. 13 – 16 hours per week
- g. 17 – 20 hours per week
- h. 21 – 24 hours per week
- i. 25 – 28 hours per week
- j. 29 – 32 hours per week
- k. 33 – 36 hours per week
- l. 37 – 40 hours per week
- m. 41 or more hours per week

15. Please indicate in which field you spend the majority of your time at your primary practice location. *If this does not apply, please select "not applicable"*

DROP-DOWN LIST OR RADIO BUTTONS

- a. Not applicable
- b. Patient Care/Documentation
- c. Teaching/Precepting/Orienting
- d. Supervision/Management/Administration
- e. Research
- f. Other

16. Please indicate which of the following best describes the area of practice of your supervising physician(s) in your primary clinical position. If this does not apply, please select "Not Applicable."

DROP-DOWN LIST OR RADIO BUTTONS

- a. Not applicable
- b. Adolescent medicine
- c. Anesthesiology
- d. Critical Care Medicine
- e. Dermatology
- f. Emergency Medicine
- g. Family Medicine/General Practice
- h. General Pediatrics
- i. Gynecology Only
- j. Hospital Medicine (Hospitalist)
- k. Internal Medicine – General Practice
- l. Internal Medicine – Allergy & Immunology
- m. Internal Medicine – Cardiology
- n. Internal Medicine – Endocrinology
- o. Internal Medicine – Gastroenterology
- p. Internal Medicine – Geriatrics
- q. Internal Medicine – Hematology
- r. Internal Medicine – Infectious Disease
- s. Internal Medicine – Nephrology
- t. Internal Medicine – Oncology
- u. Internal Medicine – Pulmonology
- v. Internal Medicine – Rheumatology
- w. Internal Medicine – Sports Medicine
- x. Neurology
- y. Obstetrics & Gynecology
- z. Occupational Medicine
- aa. Ophthalmology
- bb. Otolaryngology
- cc. Pathology
- dd. Pediatric Subspecialties
- ee. Physical Medicine/Rehabilitation
- ff. Psychiatry
- gg. Radiation Oncology
- hh. Radiology
- ii. Surgery – General
- jj. Surgery – Cardiothoracic
- kk. Surgery – Colon & Rectal
- ll. Surgery – Obstetrics & Gynecology
- mm. Surgery – Neurologic
- nn. Surgery – Ophthalmic
- oo. Surgery – Oral & Maxillofacial
- pp. Surgery – Orthopedic
- qq. Surgery – Otorhinolaryngology
- rr. Surgery – Pediatric
- ss. Surgery – Plastic & Maxillofacial
- tt. Surgery – Urology
- uu. Surgery – Vascular
- vv. Other

17. Which of the following best describes the practice setting in which your primary clinical physician assistant position is located? *If this does not apply, please select "not applicable"*

DROP-DOWN LIST OR RADIO BUTTONS



- a. Not applicable
- b. Office/Clinic – Solo Practice
- c. Office/Clinic – Partnership
- d. Office/Clinic – Single Specialty Group
- e. Office/Clinic – Multi Specialty Group
- f. Hospital – Inpatient
- g. Hospital – Outpatient
- h. Hospital – Emergency Department
- i. Hospital – Ambulatory Care Center
- j. Federal Government Hospital
- k. Research Laboratory
- l. Medical School
- m. Nursing Home or Extended Care Facility
- n. Home Health Setting
- o. Hospice Care
- p. Federal/State/Community Health Center(s)
- q. Local Health Department
- r. Telemedicine
- s. Volunteer in a Free Clinic
- t. Other

18. Is your secondary practice located in the state of Indiana? *If this does not apply, please select “not applicable”*

RADIO BUTTON

- a. Not applicable
- b. Yes
- c. No

19. If located in Indiana, what is the county of your secondary practice location? If this does not apply, please indicate “N/A”

_____ (free text)

20. If located in Indiana, what is the zip code of your secondary practice location? If this does not apply, please indicate “N/A”

_____ (free text)

21. Estimate the average number of hours per week spent at your secondary practice location. (If you do not have a secondary practice location, please *select “not applicable”*.)

DROP-DOWN LIST

- a. Not applicable
- b. 0 hours per week
- c. 1 – 4 hours per week
- d. 5 – 8 hours per week
- e. 9 – 12 hours per week
- f. 13 – 16 hours per week
- g. 17 – 20 hours per week
- h. 21 – 24 hours per week
- i. 25 – 28 hours per week
- j. 29 – 32 hours per week
- k. 33 – 36 hours per week
- l. 37 – 40 hours per week
- m. 41 or more hours per week

22. Estimate the average number of hours per week spent in direct patient care at your secondary practice location. (If you do not have a secondary practice location, *please select “not applicable”*)
DROP-DOWN LIST OR RADIO BUTTONS

- a. Not applicable
- b. 0 hours per week
- c. 1 – 4 hours per week
- d. 5 – 8 hours per week
- e. 9 – 12 hours per week
- f. 13 – 16 hours per week
- g. 17 – 20 hours per week
- h. 21 – 24 hours per week
- i. 25 – 28 hours per week
- j. 29 – 32 hours per week
- k. 33 – 36 hours per week
- l. 37 – 40 hours per week
- m. 41 or more hours per week

23. Please indicate which of the following best describes the area of practice of your supervising physician(s) in your secondary clinical position. (If you do not have a secondary practice location, *please select “not applicable”*.)

DROP DOWN OR RADIO BUTTONS

- a. Not applicable
- b. Adolescent medicine
- c. Anesthesiology
- d. Critical Care Medicine
- e. Dermatology
- f. Emergency Medicine
- g. Family Medicine/General Practice
- h. General Pediatrics
- i. Gynecology Only
- j. Hospital Medicine (Hospitalist)
- k. Internal Medicine – General Practice
- l. Internal Medicine – Allergy & Immunology
- m. Internal Medicine – Cardiology
- n. Internal Medicine – Endocrinology
- o. Internal Medicine – Gastroenterology
- p. Internal Medicine – Geriatrics
- q. Internal Medicine – Hematology
- r. Internal Medicine – Infectious Disease
- s. Internal Medicine – Nephrology
- t. Internal Medicine – Oncology
- u. Internal Medicine – Pulmonology
- v. Internal Medicine – Rheumatology
- w. Internal Medicine – Sports Medicine
- x. Neurology
- y. Obstetrics & Gynecology
- z. Occupational Medicine
- aa. Ophthalmology
- bb. Otolaryngology
- cc. Pathology
- dd. Pediatric Subspecialties
- ee. Physical Medicine/Rehabilitation
- ff. Psychiatry

- gg. Radiation Oncology
- hh. Radiology
- ii. Surgery – General
- jj. Surgery – Cardiothoracic
- kk. Surgery – Colon & Rectal
- ll. Surgery – Obstetrics & Gynecology
- mm. Surgery – Neurologic
- nn. Surgery – Ophthalmic
- oo. Surgery – Oral & Maxillofacial
- pp. Surgery – Orthopedic
- qq. Surgery – Otorhinolaryngology
- rr. Surgery – Pediatric
- ss. Surgery – Plastic & Maxillofacial
- tt. Surgery – Urology
- uu. Surgery – Vascular
- vv. Other

24. Which of the following best describes the practice setting in which your secondary clinical physician assistant position is located? (If you do not have a secondary practice location, *please select "not applicable".*)

DROP DOWN OR RADIO BUTTONS

- a. Not applicable
- b. Office/Clinic – Solo Practice
- c. Office/Clinic – Partnership
- d. Office/Clinic – Single Specialty Group
- e. Office/Clinic – Multi Specialty Group
- f. Hospital – Inpatient
- g. Hospital – Outpatient
- h. Hospital – Emergency Department
- i. Hospital – Ambulatory Care Center
- j. Federal Government Hospital
- k. Research Laboratory
- l. Medical School
- m. Nursing Home or Extended Care Facility
- n. Home Health Setting
- o. Hospice Care
- p. Federal/State/Community Health Center(s)
- q. Local Health Department
- r. Telemedicine
- s. Volunteer in a Free Clinic
- t. Other

25. Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.

CHECKBOXES

- a. Addiction counseling
- b. Dementia/Alzheimer's care
- c. Hepatitis C Treatment/Management
- d. High-risk Pregnancy services
- e. HIV/AIDS Treatment/Management
- f. Labor and delivery services
- g. MAT (Medication Assisted Treatment) – Methadone

- h. MAT (Medication Assisted Treatment) – Buprenorphine
- i. MAT (Medication Assisted Treatment) – Naltrexone
- j. Post-natal services
- k. Pre-natal services
- l. Screening for addiction (ex: SBIRT)
- m. Screening for high-risk pregnancy
- n. Treatment of OUD-affected Pregnant Women
- o. None of the above

26. Please indicate the population groups to which you provide services:

CHECKBOXES

- a. Newborns
 - b. Children (ages 2-10)
 - c. Adolescents (ages 11-19)
 - d. Adults
 - e. Geriatrics (ages 65+)
 - f. Pregnant women
 - g. Inmates
 - h. Disabled individuals
 - i. Individuals in recovery
 - j. None of the above
27. What is your highest level of education?
- a. Certificate/diploma
 - b. Associate degree
 - c. Bachelor's degree
 - d. Master's degree
 - e. Doctorate degree
 - f. Military training certification
 - g. Other