

**18. WHICH BEST DESCRIBES YOUR PRINCIPAL AND, AS APPLICABLE, SECONDARY WORK SETTING(S).**

(Mark only one in each column.)

Principal	Secondary	
<input type="radio"/>	<input type="radio"/>	Health center, clinic, or hospital outpatient
<input type="radio"/>	<input type="radio"/>	Hospital emergency room/department
<input type="radio"/>	<input type="radio"/>	Hospital inpatient unit
<input type="radio"/>	<input type="radio"/>	Midwife-owned private practice
<input type="radio"/>	<input type="radio"/>	Physician practice
<input type="radio"/>	<input type="radio"/>	State/County public health department
<input type="radio"/>	<input type="radio"/>	Other (specify): _____

**19. IF YOU WORK IN A PHYSICIAN PRACTICE, WHAT BEST DESCRIBES THE SPECIALTY OF THAT PRACTICE?**  
(Mark one in each column if applicable.)

Principal	Secondary	
<input type="radio"/>	<input type="radio"/>	Family Medicine
<input type="radio"/>	<input type="radio"/>	General Practice
<input type="radio"/>	<input type="radio"/>	Obstetrics and Gynecology
<input type="radio"/>	<input type="radio"/>	Perinatology
<input type="radio"/>	<input type="radio"/>	Other (specify): _____

**20. DO YOU ATTEND DELIVERIES?**

Yes  
 No

**If you answered no to question 20, skip to question 22.**

**21. IF YOU ATTEND DELIVERIES, WHAT PERCENT OF YOUR INTRAPARTUM CARE DO YOU PROVIDE IN:**

	0%	1%-25%	26%-50%	51%-75%	76%-100%
Hospital labor & delivery rooms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospital birthing centers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Free-standing birthing centers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Homes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**22. DOES YOUR PRINCIPAL PRACTICE SITE USE AN ELECTRONIC HEALTH RECORD (EHR)? An EHR is a computerized version of a patient's medical information.**

Yes, all electronic  
 Yes, part paper, part electronic  
 No  
 Don't know

**23A. DOES YOUR PRINCIPAL PRACTICE SITE USE A COMPUTERIZED SYSTEM ...**

	Yes	No
for computerized provider order entry (CPOE)?	<input type="radio"/>	<input type="radio"/>
to generate/transmit prescriptions? (excluding fax)	<input type="radio"/>	<input type="radio"/>
to record patient demographics?	<input type="radio"/>	<input type="radio"/>
to record patient smoking status?	<input type="radio"/>	<input type="radio"/>
to maintain patient problem lists on current and active diagnoses?	<input type="radio"/>	<input type="radio"/>
for drug-drug and drug-allergy interaction checks?	<input type="radio"/>	<input type="radio"/>
to maintain active medication lists?	<input type="radio"/>	<input type="radio"/>
to maintain medication allergy lists?	<input type="radio"/>	<input type="radio"/>
to record and chart changes in patient vital signs?	<input type="radio"/>	<input type="radio"/>
for at least one clinical decision support rule?	<input type="radio"/>	<input type="radio"/>
to report clinical quality measures to CMS/state?	<input type="radio"/>	<input type="radio"/>
to provide patient with electronic copy of their health information?	<input type="radio"/>	<input type="radio"/>
to provide patient with a clinical summary for each office visit?	<input type="radio"/>	<input type="radio"/>

**23B. DOES YOUR PRINCIPAL PRACTICE SITE ...**

	Yes	No
have the capacity to exchange key clinical information?	<input type="radio"/>	<input type="radio"/>
send clinical information through a Regional Health Information Organization (RHIO)?	<input type="radio"/>	<input type="radio"/>
receive clinical information through a RHIO?	<input type="radio"/>	<input type="radio"/>
protect confidential electronic health information?	<input type="radio"/>	<input type="radio"/>

**24. IN YOUR EXPERIENCE, WHICH OF THE FOLLOWING IS (ARE) THE MOST SUBSTANTIAL BARRIER(S) TO CURRENT MIDWIFERY PRACTICE? (Mark all that apply.)**

High cost of liability insurance  
 Inability to obtain liability insurance  
 Inability to establish a relationship with physician/institution  
 Low insurance reimbursement for midwifery services  
 Inability to obtain hospital admitting privileges  
 Other (specify): \_\_\_\_\_  
 None

**25. IN THE NEXT 12 MONTHS, DO YOU PLAN TO: (Mark all that apply.)**

Retire from patient care?  
 Significantly reduce patient care hours?  
 Move to another location in NY and continue practicing?  
 Move to another state and continue practicing?  
 None of the above.

**New York State Education Department**

**Midwife Survey**

This questionnaire is a supplemental part of your registration application. Please complete and return it with the registration form and fee in the envelope provided. If you complete the survey online, you do not have to complete this form.

Your responses will be maintained in a strictly confidential manner by the Center for Health Workforce Studies (<http://chws.albany.edu>) at the School of Public Health, University at Albany, SUNY. The responses will be analyzed and presented only in aggregate form to document trends in the midwifery workforce in New York.

Item 2 asks for your NYS midwifery license number. This can be found on the enclosed registration application. Thank you for taking the time to complete this survey.

**INSTRUCTIONS**

- Make dark marks that completely fill the circle.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.

**CORRECT:** ● **INCORRECT:** ○

**BASIC INFORMATION**

**1. DATE COMPLETING SURVEY**

Month			Year
<input type="radio"/> Jan	<input type="radio"/> May	<input type="radio"/> Sep	<input type="radio"/> 2011
<input type="radio"/> Feb	<input type="radio"/> Jun	<input type="radio"/> Oct	<input type="radio"/> 2012
<input type="radio"/> Mar	<input type="radio"/> Jul	<input type="radio"/> Nov	<input type="radio"/> 2013
<input type="radio"/> Apr	<input type="radio"/> Aug	<input type="radio"/> Dec	<input type="radio"/> 2014

**2. NYS Midwifery License No.**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**3. NYS RN License No. (If Applicable)**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**4. Year of Birth**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**5. Gender**  Female  Male

SERIAL

**6. RACE (Mark all that apply.)**

- African American/Black
- American Indian /Alaska Native
- Asian/Pacific Islander
- White
- Other

**7. ETHNICITY: ARE YOU HISPANIC/LATINO?**

- Yes
- No

**8. LANGUAGES IN WHICH YOU ARE FLUENT (Mark all that apply.)**

- English
- Cantonese
- Italian
- Mandarin
- Russian
- Spanish
- Any African Language(s)
- Other European Language(s)
- Other Asian/Middle Eastern Language(s)
- Other (specify): \_\_\_\_\_

**9. LOCATION OF EDUCATION**

	Location of high school from which you graduated	Location of bachelor's program from which you graduated (if applicable)	Location of midwifery education program from which you graduated
New York	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other state in the U.S.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Outside the U.S.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**10. EDUCATION (Mark one in each column, if applicable.)**

	Highest nursing degree (if applicable)	Highest non-nursing degree
Diploma/Associate	<input type="radio"/>	<input type="radio"/>
Bachelor's degree	<input type="radio"/>	<input type="radio"/>
Master's degree	<input type="radio"/>	<input type="radio"/>
Doctorate	<input type="radio"/>	<input type="radio"/>

**11. MIDWIFERY EDUCATION (Mark all that apply.)**

- Bachelor's degree
- Master's degree
- Doctorate
- Midwifery certificate

**12. WHAT YEAR DID YOU GRADUATE FROM YOUR MIDWIFERY EDUCATION PROGRAM?**



Yr. of Grad		
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

**13. FROM WHICH NATIONAL ORGANIZATION DO YOU HOLD A MIDWIFERY CERTIFICATE? (Mark all that apply.)**

- American Midwifery Certification Board
- North American Registry of Midwives
- Other (specify): \_\_\_\_\_

**CURRENT WORK**

**14. FOR HOW MANY YEARS HAVE YOU WORKED IN POSITIONS AS A MIDWIFE? If less than one year, indicate one year.**



Yrs.	
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

**15. CURRENT EMPLOYMENT STATUS. (Mark all that apply.)**

- Working in at least one position that requires a midwife license
- Working in a position that only requires an RN license
- Working, but not as a midwife or RN
- Volunteering in a position requiring a midwife license
- Not currently working
- Retired

**16. FOR ALL MIDWIFERY POSITIONS HELD, INDICATE THE AVERAGE NUMBER OF HOURS SPENT PER WEEK ON EACH MAJOR ACTIVITY. (Exclude overtime.)**

	Hours/Week						
	None	1-9	10-19	20-29	30-39	40-49	50+
Patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Research	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Teaching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Administration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**If you spend any of your work time providing patient care in midwifery, continue with the survey, otherwise STOP here and return the survey.**

**17. MIDWIFERY PATIENT CARE: PRACTICE LOCATIONS**

Location of site(s) where you spend the most time providing patient care as a midwife. Print the address(es) of your practice location(s) including the zip code. Also, indicate the average number of patient care hours per week you spend at each practice location.

**Principal Location**

Number \_\_\_\_\_ Street \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_

Zip Code	Avg. Patient Care Hours Per Week
0 0 0 0 0	0 0
1 1 1 1 1	1 1
2 2 2 2 2	2 2
3 3 3 3 3	3 3
4 4 4 4 4	4 4
5 5 5 5 5	5 5
6 6 6 6 6	6 6
7 7 7 7 7	7 7
8 8 8 8 8	8 8
9 9 9 9 9	9 9

**Secondary Location**

Number \_\_\_\_\_ Street \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_

Zip Code	Avg. Patient Care Hours Per Week
0 0 0 0 0	0 0
1 1 1 1 1	1 1
2 2 2 2 2	2 2
3 3 3 3 3	3 3
4 4 4 4 4	4 4
5 5 5 5 5	5 5
6 6 6 6 6	6 6
7 7 7 7 7	7 7
8 8 8 8 8	8 8
9 9 9 9 9	9 9