15. PLEASE INDICATE THE SPECIALTY OF YOUR SUPERVISING PHYSICIAN. ***(Mark ONE principal specialty and, if applicable, ONE secondary specialty.)***

Principal	Secondary	
○	○	Allergy and Immunology
○	○	Dermatology
○	○	Emergency Medicine
○	○	Family Medicine
○	○	General Practice
○	○	Internal Medicine (General)
○	○	Cardiovascular Disease
○	○	Critical Care
○	○	Endocrinology, Diabetes and Metabolism
○	○	Gastroenterology
○	○	Geriatrics
○	○	Infectious Disease
○	○	Medical Oncology
○	○	Other Internal Medicine Sub-specialty
○	○	Obstetrics and Gynecology
○	○	Occupational Medicine
○	○	Otolaryngology
○	○	Pediatrics (General)
○	○	Pediatrics (Sub-specialty)
○	○	Radiology
○	○	Surgery (General)
○	○	Cardiovascular Surgery
○	○	Neurological Surgery
○	○	Orthopedic Surgery
○	○	Other Surgical Sub-specialty
○	○	Other *(specify)*: _____

16. WHAT PERCENT OF YOUR PATIENTS HAVE THE FOLLOWING PRIMARY SOURCE OF PAYMENT?

	Medicaid	Medicare	Other Govt*	Self-pay	All Other**
0%	○	○	○	○	○
1 - 9%	○	○	○	○	○
10 - 19%	○	○	○	○	○
20 - 29%	○	○	○	○	○
30 - 39%	○	○	○	○	○
40 - 49%	○	○	○	○	○
50 - 59%	○	○	○	○	○
60 - 69%	○	○	○	○	○
70 - 79%	○	○	○	○	○
80 - 89%	○	○	○	○	○
90 - 99%	○	○	○	○	○
100%	○	○	○	○	○

** Includes Child & Family Health Plus, Tricare, etc.*

*** Includes commercially insured.*

17. 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

18A. DOES YOUR PRINCIPAL PRACTICE SITE USE A COMPUTERIZED SYSTEM ...

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

18B. DOES YOUR PRINCIPAL PRACTICE SITE ...

	Yes	No
exchange key clinical information with other providers?	○	○
send clinical information through a Regional Health Information Organization (RHIO)?	○	○
receive clinical information through a RHIO?	○	○
protect confidential electronic health information?	○	○

19. IN THE NEXT 12 MONTHS, DO YOU PLAN TO:

- ○ 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.

SERIAL

New York State Education Department

Physician Assistant 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 physician assistant workforce in New York.

Item 2 asks for your NYS Physician Assistant 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
○ Jan	○ May	○ Sep	○ 2011
○ Feb	○ Jun	○ Oct	○ 2012
○ Mar	○ Jul	○ Nov	○ 2013
○ Apr	○ Aug	○ Dec	○ 2014

2. NYS License No.

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

3. Yr. of Birth

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

4. Gender ○ Female ○ Male

5. RACE/ETHNICITY ***(Mark all that apply.)***

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

Hispanic/Latino?

- ◯ Yes
- ◯ No

6. 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):* _____

EDUCATION

7. LOCATION OF EDUCATION

	Location of high school from which you graduated	Location of first PA education program from which you graduated	Location of first college from which you graduated (if different than PA education program)
New York	◯	◯	◯
Other state in the U.S.	◯	◯	◯
Outside the U.S.	◯	◯	◯

8. INDICATE YOUR PHYSICIAN ASSISTANT EDUCATION OR TRAINING. ***(Mark all that apply.)***

- ◯ Bachelor's Degree
- ◯ Master's Degree
- ◯ Certificate
- ◯ Military Training

9. WHAT YEAR OF DID YOU GRADUATE FROM YOUR FIRST PA EDUCATION OR TRAINING PROGRAM?

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

10. FOR HOW MANY YEARS HAVE YOU WORKED AS A PHYSICIAN ASSISTANT? ***(If less than one year, indicate one year.)***

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

CURRENT WORK

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

- ◯ Working in at least one position that requires a PA licence
- ◯ Working, but not as a physician assistant
- ◯ Volunteering in a position that requires a PA license
- ◯ Not currently working
- ◯ Retired

12. FOR ALL PHYSICIAN ASSISTANT 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							
Primary care*	◯	◯	◯	◯	◯	◯	◯
All other patient care	◯	◯	◯	◯	◯	◯	◯
Research	◯	◯	◯	◯	◯	◯	◯
Teaching	◯	◯	◯	◯	◯	◯	◯
Administration	◯	◯	◯	◯	◯	◯	◯
Other	◯	◯	◯	◯	◯	◯	◯

* ***Primary care is defined as first contact and continuing care, including basic or initial diagnosis and treatment, health supervision, management of chronic conditions, preventive health services, and appropriate referral(s).***

If you spend any of your work time providing PA-related patient care services, continue with the survey, otherwise STOP here and return the survey.

13. WHICH BEST DESCRIBES YOUR PRINCIPAL AND, AS APPLICABLE, SECONDARY WORK SETTING(S)? ***(Mark only one in each column.)***

Principal	Secondary	
◯	◯	Health center, clinic, or hospital outpatient
◯	◯	Hospital emergency room/department
◯	◯	Hospital inpatient unit
◯	◯	Nursing home/long term care
◯	◯	Physician practice
◯	◯	State/county public health department
◯	◯	Urgent care center
◯	◯	Other *(specify)*: _____

14. PA PATIENT CARE PRACTICE LOCATIONS

Location of site(s) where you spend the most time providing patient care. 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: 0 1 2 3 4 5 6 7 8 9

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

Secondary Location

Number Street

City/Town State

Zip Code: 0 1 2 3 4 5 6 7 8 9

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