

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

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

**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)?                  | <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 pt. problem lists on current & 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 pt. an electronic copy of their health information? | <input type="radio"/> | <input type="radio"/> |
| to provide pt. with a clinical summary for each office visit?  | <input type="radio"/> | <input type="radio"/> |

**18B. DOES YOUR PRINCIPAL PRACTICE SITE ...**

|  | Yes                   | No                    |
|--|-----------------------|-----------------------|
| exchange key clinical information with other providers?                              | <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"/> |

**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.

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

|          | Medicaid              | Medicare              | Other Govt*           | Self-pay              | All Other**           |
|----------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 0%       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 1 - 9%   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10 - 19% | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20 - 29% | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30 - 39% | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 40 - 49% | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 50 - 59% | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 60 - 69% | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 70 - 79% | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 80 - 89% | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 90 - 99% | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 100%     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

\* Includes Child & Family Health Plus, Tricare, etc.  
 \*\* Includes commercially insured.

**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                       |
|---------------------------|---------------------------|---------------------------|----------------------------|
| <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 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

SERIAL

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

|  |   |
|--|---|
| <input type="radio"/> African American/Black         | Hispanic/Latino?<br><input type="radio"/> Yes<br><input type="radio"/> No |
| <input type="radio"/> American Indian /Alaska Native |   |
| <input type="radio"/> Asian/Pacific Islander         |   |
| <input type="radio"/> White                          |   |
| <input type="radio"/> Other                          |   |

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

|                                 |  |
|---------------------------------|--|
| <input type="radio"/> English   | <input type="radio"/> Spanish                                |
| <input type="radio"/> Cantonese | <input type="radio"/> Any African language(s)                |
| <input type="radio"/> Italian   | <input type="radio"/> Other European language(s)             |
| <input type="radio"/> Mandarin  | <input type="radio"/> Other Asian/Middle Eastern language(s) |
| <input type="radio"/> Russian   | <input type="radio"/> 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                | <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"/>   |

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

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

|      |   |   |
|------|---|---|
| Yrs. | 0 | 0 |
| 1    | 1 | 1 |
| 2    | 2 | 2 |
|      | 3 | 3 |
|      | 4 | 4 |
|      | 5 | 5 |
|      | 6 | 6 |
|      | 7 | 7 |
|      | 8 | 8 |
|      | 9 | 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*          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| All other 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"/> |

\* **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   |
|-----------------------|---|
| <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"/> Nursing home/long term care                   |
| <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"/> Urgent care center                            |
| <input type="radio"/> | <input type="radio"/> 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 \_\_\_\_\_

|  |                 |  |
|--|-----------------|--|
|  | <b>Zip Code</b> | <b>Avg Patient Care Hours Per Week</b> |
|  | 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 \_\_\_\_\_

|  |                 |  |
|--|-----------------|--|
|  | <b>Zip Code</b> | <b>Avg Patient Care Hours Per Week</b> |
|  | 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                                    |