18 PRACTICE SPECIALTY IN WHICH YOU SPEND MOST OF YOUR PROFESSIONAL TIME

Mark ONE principal specialty and ONE secondary specialty, if applicable.

Principal	Secondary	
◯	◯	**Allergy & Immunology**
◯	◯	**Anesthesiology**
◯	◯	**Dermatology**
◯	◯	**Emergency Medicine**
◯	◯	**Family Medicine**
◯	◯	**General Practice**
◯	◯	**Internal Medicine (General)**
◯	◯	Cardiovascular Disease
◯	◯	Critical Care
◯	◯	Endocrinology, Diabetes and Metabolism
◯	◯	Gastroenterology
◯	◯	Geriatrics
◯	◯	Infectious Disease
◯	◯	Medical Oncology
◯	◯	Nephrology
◯	◯	Pulmonary Disease
◯	◯	Rheumatology
◯	◯	Other Internal Medicine Sub-specialty
◯	◯	**Neurology**
◯	◯	**Obstetrics and Gynecology**
◯	◯	**Gynecology (Only)**
◯	◯	**Occupational Medicine**
◯	◯	**Ophthalmology**
◯	◯	**Otolaryngology**
◯	◯	**Pathology (General)**
◯	◯	Pathology (Sub-specialty)
◯	◯	**Pediatrics (General)**
◯	◯	Pediatrics (Sub-specialty)
◯	◯	**Physical Medicine and Rehabilitation**
◯	◯	**Preventive Medicine**
◯	◯	**Psychiatry—Adult**
◯	◯	**Psychiatry—Child & Adolescent**
◯	◯	**Radiology—Diagnostic**
◯	◯	**Radiology—Therapeutic**
◯	◯	**Surgery (General)**
◯	◯	Surgery, Neurological
◯	◯	Surgery, Orthopedic
◯	◯	Surgery, Plastic
◯	◯	Surgery, Thoracic
◯	◯	Other Surgical Sub-specialty
◯	◯	**Urology**
◯	◯	**Other**

SERIAL

19 What percent of your direct patient care time is spent in your principal specialty?

◯ 0% ◯ 1-19% ◯ 20-39% ◯ 40-59%
◯ 60-79% ◯ 80-99% ◯ 100%

20 Training and Certification:

	Completed Accredited Residency Program		Board Certified/Cert. of Added/Special Qualification	
Principal Specialty	Ⓨ	Ⓝ	Ⓨ	Ⓝ
Secondary Specialty	Ⓨ	Ⓝ	Ⓨ	Ⓝ

21 In the next year, do you plan to: (Mark all that apply.)

◯ Retire from patient care?
◯ Significantly reduce patient care hours?
◯ Move your practice to a location in New York?
◯ Move your practice out of New York?

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

23 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 patient 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 patients an electronic copy of their health information?	◯	◯
to provide patients with a clinical summary for each office visit?	◯	◯

24 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?	◯	◯

New York State Education Department

Physician 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 changes in the physician workforce in New York.

Item 2 asks for your NYS license number. This number 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: ✓ ⊗ ◒ ◔

1 DATE ON WHICH YOU ARE COMPLETING SURVEY

A				B	
◯	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 GENDER

◯ Male
◯ Female

4 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

5 RACE/ETHNICITY (Mark all that apply.)

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

Hispanic/Latino?
◯ Yes
◯ No

6 CURRENT WORK STATUS IN MEDICINE

- ◯ Full time (30 hrs or more per week)
- ◯ Part time (less than 30 hrs per week)
- ◯ Inactive in medicine
- ◯ Retired

NOTE: If you are inactive in medicine or retired, *STOP HERE* and return the questionnaire with the registration form and fee in the envelope provided.

7 CURRENT TRAINING STATUS

◯ Resident ◯ Fellow ◯ Neither

8 CURRENT ACTIVITIES IN MEDICINE

Please indicate hours per week in medicine for which the major activity is:

	Hours/Week						
	None	1-9	10-19	20-29	30-39	40-49	50+
Patient Care	◯	◯	◯	◯	◯	◯	◯
Research	◯	◯	◯	◯	◯	◯	◯
Teaching	◯	◯	◯	◯	◯	◯	◯
Administration	◯	◯	◯	◯	◯	◯	◯

9 LOCATION OF EDUCATION

Residence upon graduation from high school	Location of medical school from which you graduated	Location of most recent residency training	
◯	◯	◯	New York
◯	◯	◯	Other state in the U.S.
◯	◯	◯	Canada
◯	◯	◯	Other foreign country

10 MEDICAL SCHOOL

A. ◯ Allopathic ◯ Osteopathic

B. Year graduated medical school: YR OF GRAD

C. If you graduated medical school in *New York*, indicate school:

- ◯ Albany Medical College
- ◯ Albert Einstein (Yeshiva University)
- ◯ Columbia University
- ◯ Cornell University
- ◯ Mount Sinai School of Medicine
- ◯ New York College of Osteopathic Medicine
- ◯ New York Medical College
- ◯ New York University
- ◯ SUNY Brooklyn
- ◯ SUNY at Buffalo
- ◯ SUNY at Stony Brook
- ◯ SUNY Syracuse
- ◯ Touro College of Osteopathic Medicine
- ◯ University at Rochester

11 Number of hospitals in New York at which you have admitting privileges:

◯ None ◯ One ◯ Two ◯ Three or more

12 PATIENT CARE: PRACTICE LOCATIONS

Location of sites where you spend the most time providing direct patient care. Print the address(es) of your practice location(s) including the 5-digit zip code. Also, indicate the average number of hours per week you spend at each practice location and a description of each location.

Principal Location

Number Street

City/Town State

Zip Code | Patient Care Hours

This location is a/an: (Mark all that apply.)

- ◯ Private office/medical arts building
- ◯ Hospital
- ◯ Freestanding health center/clinic/urgent care center
- ◯ Nursing home/other residential facility
- ◯ State/local health department
- ◯ Other

Secondary Location

Number Street

City/Town State

Zip Code | Patient Care Hours

This location is a/an: (Mark all that apply.)

- ◯ Private office/medical arts building
- ◯ Hospital
- ◯ Freestanding health center/clinic/urgent care center
- ◯ Nursing home/other residential facility
- ◯ State/local health department
- ◯ Other

13 PATIENT CARE: PRACTICE TYPE

Which best describes your patient care practice at the locations identified in question 12? Mark one for principal and one for secondary practice location, where applicable.

Principal	Secondary	
◯	◯	Ambulatory care (incl. hospital outpt services)
◯	◯	Inpatient care
◯	◯	Emergency services (emergency room/dept.)
◯	◯	Other

14 PATIENT CARE: PRACTICE SIZE

How many physicians work in your practice(s)? Mark one for principal and one for secondary practice location, where applicable.

Principal	Secondary	
◯	◯	1 physician
◯	◯	2-5 physicians
◯	◯	6-10 physicians
◯	◯	11-20 physicians
◯	◯	21-50 physicians
◯	◯	More than 50 physicians

15 What percent of your patients have the following primary sources of payment?

	Medicare	Medicaid	Self Pay	All Other
0%	◯	◯	◯	◯
1-4%	◯	◯	◯	◯
5-9%	◯	◯	◯	◯
10-19%	◯	◯	◯	◯
20-29%	◯	◯	◯	◯
30-39%	◯	◯	◯	◯
40-49%	◯	◯	◯	◯
50-59%	◯	◯	◯	◯
60-79%	◯	◯	◯	◯
80-99%	◯	◯	◯	◯
100%	◯	◯	◯	◯

16 Which statement best describes your malpractice liability insurance coverage?

- ◯ I pay for my individual policy.
- ◯ My employer/practice pays for/provides my insurance coverage.
- ◯ I do not carry malpractice liability insurance.
- ◯ Other

17 Mark the statement that best describes your patient care practice status.

- ◯ I cannot accept any additional patients; my practice is full.
- ◯ I can accept some additional patients; my practice is nearly full.
- ◯ I can accept many additional patients; my practice is far from full.