2022 Pharmacist License Renewal Survey Instrument

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 degree/credential qualified you for your first U.S. pharmacist license?
   RADIO BUTTONS
   a. Certificate
   b. Associate
   c. Bachelors
   d. Masters
   e. Doctor of Pharmacy

5. Where did you complete your pharmacist education that first qualified you for your U.S. pharmacist 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. What year did you complete the pharmacist education that first qualified you for your U.S. pharmacist license? Please indicate using the four digit year.
   TEXT BOX

7. Have you completed a pharmacy fellowship?
   RADIO BUTTONS
   a. Yes
   b. No

8. If you have completed a residency, in which specialty was your residency program? If you did not complete a residency, if this does not apply, please indicate “Not Applicable”
   CHECK BOXES
   a. Ambulatory Care
   b. Cardiology
   c. Community
   d. Critical Care
   e. Drug Information
   f. Emergency Medicine
   g. Geriatric
   h. Infectious Diseases
   i. Informatics
   j. Internal Medicine
   k. Managed Care Pharmacy Systems
   l. Medication-Use Safety
   m. Nuclear
   n. Nutrition Support
   o. Oncology
   p. Pediatric
   q. Pharmacotherapy
   r. Health-System Pharmacy Administration
   s. Psychiatric
   t. Solid Organ Transplant
   u. Not Applicable

9. What is your employment status?
   RADIO BUTTONS OR DROP DOWN
   a. Actively working in a position that requires a pharmacist license
   b. Actively working in a pharmacy related field that does not require a pharmacist license
   c. Actively working in a non-pharmacy related field that does not require a pharmacist license
   d. Not currently working
   e. Student
   f. Leave of absence or Sabbatical
   g. Retired

10. What are your employment plans for the next 12 months?
    RADIO BUTTONS
    a. Increase hours in the pharmacy field
    b. Decrease hours in the pharmacy field
    c. Leave employment in the field of pharmacy
    d. No planned change

11. How many weeks did you work as a pharmacist in the past year? Please approximate and enter a number 0 through 52 (no decimals).
    TEXT BOX

12. Please indicate in which field you spend the majority of your time. If this does not apply, please select “not applicable.”
    a. DROP-DOWN LIST OR RADIO BUTTONS
    b. Medication Dispensing
    c. Patient Care Services

d. Business/Organization Management
e. Research
f. Education
g. Other
h. Not applicable

13. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"
DROP-DOWN LIST (including N/A)

14. If located in Indiana, what is the county of your primary practice location? If this does not apply, please indicate "N/A"_____ (free text)

15. 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)

16. How many total hours do you spend per week at your primary practice location? If this does not apply, please select "not applicable."
DROP-DOWN LIST OR RADIO BUTTONS
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week
    m. Not Applicable

17. Please approximate the percentage of your time that you spend providing <u>patient care</u> services at your primary practice location (**excluding** medication dispensing, education, research, and business activities).
DROP DOWN
    a. 0%
    b. 10%
    c. 20%
    d. 30%
    e. 40%
    f. 50%
    g. 60%
    h. 70%
    i. 80%
    j. 90%
    k. 100%

18. Please identify the type of setting that most closely corresponds to your primary practice position. If this does not apply, please select “Not Applicable”
    DROP DOWN
    a. Community Pharmacy
    b. Mass Merchandiser (i.e. Big Box store)
    c. Supermarket Pharmacy
    d. Clinic-Based Pharmacy
    e. Mail Service Pharmacy
    f. Health Center (CHC/FQHC/FQHC look-alike)
    g. Federal Government Hospital/Health System – Inpatient
    h. Federal Government Hospital/Health System - Outpatient clinic owned by or located at hospital
    i. Non-government Hospital/Health System - Inpatient
    j. Non-government Hospital/Health System - Outpatient clinic owned by or located at hospital
    k. Non-government Hospital/Health System - Other
    l. Nursing Home/Long Term Care
    m. Home Health/Infusion
    n. Pharmacy Benefit Administration (e.g. PBM, managed care)
    o. School-based health service
    p. Academic Institution
    q. Occupational health
    r. Telepharmacy
    s. Ambulatory care office-based practice
    t. Ambulatory care community pharmacy-based practice
    u. Other
    v. Regulatory Practice
    w. Not Applicable

19. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select “N/A”
    DROP-DOWN LIST including N/A

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

    _____ (free text)

21. 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)

22. How many hours do you spend per week at your secondary practice location? If this does not apply, please indicate “Not Applicable.”
    DROP-DOWN LIST OR RADIO BUTTONS
    a. 0 hours per week
    b. 1 – 4 hours per week

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

23. Please approximate the percentage of your time that you spend providing patient care services at your secondary practice location (excluding medication dispensing, education, research, and business activities). If this does not apply, please indicate “Not Applicable.”
DROP DOWN
    a. 0%
    b. 10%
    c. 20%
    d. 30%
    e. 40%
    f. 50%
    g. 60%
    h. 70%
    i. 80%
    j. 90%
    k. 100%
    l. Not Applicable

24. Please identify the type of setting that most closely corresponds to your secondary practice location. If this does not apply, please indicate “Not Applicable.”
DROP DOWN
    a. Community Pharmacy
    b. Mass Merchandiser (i.e. Big Box store)
    c. Supermarket Pharmacy
    d. Clinic-Based Pharmacy
    e. Mail Service Pharmacy
    f. Health Center (CHC/FQHC/FQHC look-alike)
    g. Federal Government Hospital/Health System – Inpatient
    h. Federal Government Hospital/Health System - Outpatient clinic owned by or located at hospital
    i. Non-government Hospital/Health System - Inpatient
    j. Non-government Hospital/Health System - Outpatient clinic owned by or located at hospital
    k. Non-government Hospital/Health System - Other
    l. Nursing Home/Long Term Care
    m. Home Health/Infusion
    n. Pharmacy Benefit Administration (e.g. PBM, managed care)
    o. School-based health service

p. Academic Institution
q. Occupational health
r. Telepharmacy
s. Ambulatory care office-based practice
t. Ambulatory care community pharmacy-based practice
u. Other
v. Regulatory Practice
w. Not Applicable

25. Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purpose of this services list is to gather information on key health issues in Indiana). Please check all that apply.
    CHECKBOXES
    a. None of the above
    b. Administer immunizations
    c. Drug evaluation, drug utilization review, and drug regimen review.
    d. Drug or drug-related research
    e. Obtain/maintain patient drug histories and other pharmacy records
    f. Prescribe permitted devices or supplies (Ex: Inhalation spacer, Nebulize, Supplies for medical devices, Normal saline and sterile water for irrigation for wound care, Diabetes blood sugar testing supplies, Pen needles, Syringes for medication use)
    g. Remote dispensing facility
    h. Remote patient care services (telepharmacy/telehealth)
    i. Selection, storage, and distribution of drugs, dietary supplements, and devices.
    j. Supervise pharmacy interns, pharmacy technicians, or pharmacy technicians in training
    k. Supervise a licensed pharmacy technician employed at a remote dispensing facility
    l. Tobacco cessation services
    m. Utilize Prescription Drug Monitoring Program (PDMP – INSPECT in Indiana)

26. Please indicate the population groups to which you provide services:
    MULTI-SELECT
    □ None of the above
    □ Newborns
    □ Children (ages 2-10)
    □ Adolescents (ages 11-19)
    □ Adults
    □ Geriatrics (ages 65+)
    □ Pregnant women
    □ Inmates
    □ Disabled individuals
    □ Individuals in recovery