NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs *for all*
Department of Health and Human Services

New Hampshire Physician Licensure Survey

Physician Name: _____

Email: _____ **Date of Birth:** ____ / ____ / ____

1. **Please enter the NH License Number assigned to you**: _____

2. **Sex**: ☐ Male ☐ Female

3. **10-digit NPI number:** _____ **No NPI number** ☐
   Note: If you do not know your NPI number, please visit https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do to locate it.

4. **Are you Hispanic/Latino?**
   ☐ Yes ☐ No

5. **Race:** (Select all that apply)
   ☐ White; ☐ Black or African American; ☐ Amer. Indian or Alaska Native; Asian (☐ Indian, ☐ Chinese, ☐ Filipino, ☐ Japanese, ☐ Korean, ☐ Vietnamese, ☐ Other _____); Native Hawaiian or Other Pacific Islander (☐ Guamanian or Chamorro, ☐ Samoan, ☐ Native Hawaiian, ☐ Other _____)

6. **Do you speak another language other than English in your clinical practice**?
   ☐ Yes ☐ No

   6a. **If yes, what language(s)?** (Select all that apply)

   ☐ Spanish, ☐ Portuguese, ☐ French, ☐ German, ☐ Other European, ☐ Arabic, ☐ Chinese, ☐ Other East Asian, ☐ Hindi, ☐ Other South/Southeast Asian, ☐ American Sign Language, ☐ Other _____

7. **Which best describes your current practice status in NH?** (Select one)
Note: Remainder of survey pertains only to providers engaged in full/part time clinical practice in NH

☐ Full/Part time clinical practice at one or more locations in NH
(Select this option if you work more than 2 scheduled hours per week/8 hours per month.)
☐ Clinical work as a Locum Tenens at one location for one year or longer

If you did not check one of the two boxes above, please check the appropriate box below and skip the remainder of the survey

☐ Clinical work as a Locum Tenens for less than one year at one location
☐ Infrequent clinical practice (less than 2 scheduled hours per week/8 hours per month)
☐ Medical Administrative/Legal services ONLY
☐ Clinical teaching/Clinical research ONLY
☐ Other work using medical license/training
☐ No clinical or medical related work within NH
☐ Not currently working; If checked: ☐ Unemployed/Looking ☐ On extended leave ☐ Other
☐ Retired

8. **Where did you graduate from medical school (name of school, state)**?

_____

9. **Year you graduated from medical school**: _____

10. **Additional training information:**
Note: Your principal specialty is the specialty you currently spend the most time practicing.

	Completed Accredited Residency Program/Fellowship?
Principal Specialty	☐ No ☐ Yes; State _____
Secondary Specialty *(If applicable)*	☐ No ☐ Yes; State _____
Tertiary Specialty *(If applicable)*	☐ No ☐ Yes; State _____

11. **Do you currently hold a waiver for the prescription of buprenorphine?**

☐ Yes ☐ No

11a. If yes, are you currently prescribing at the patient limit for this medication? ☐ Yes ☐ No

12. **Are you a foreign citizen currently in the US on a work Visa?**

☐ Yes ☐ No

13. **Are you currently obligated under the J-1 Visa Waiver Program to work at your clinical practice(s) in NH?**

☐ Yes ☐ No

14. **Are you <u>currently</u> an obligated provider under the National Health Service Corps program (scholarship or loan repayment)?**

Note: These are programs that cover medical education costs or offer loan repayment in return for working in a federally designated shortage area for a specified period of time.

☐ Yes ☐ No

15. **Did you live or work in NH prior to receiving your NH license?**

☐ Yes ☐ No

16. **How many years have you practiced clinical medicine in NH, as a physician?**

_____ years

17. **Do you expect that you will be practicing medicine in NH 5 years from now?**

☐ Yes, at about the same level I'm currently working
☐ Yes, but I expect to increase my hours
☐ Yes, but I expect to reduce my hours
☐ No, but I expect to be practicing in another state
☐ No, I do not plan to practice medicine 5 years from now

18. **How many total hours per week do you typically spend providing clinical medicine <u>across all service locations</u> *(i.e. locations with scheduled services of at least 2+ hours per week)*?**

Note: Clinical services include direct patient care, as well as any administrative activities related to charting, billing for services, and participation in clinical team activities. It does not include time spent on managerial and oversight activities of the organization or clinical team.

_____ *(hours per week)*

NH PRACTICE SITE QUESTIONS

The following questions should be completed for <u>each location</u> at which you routinely practice medicine (i.e. at least 2+ hours of scheduled services per week). ***Note:*** *If you are a telemedicine provider, please provide the address in which you are stationed, not for which you provide care. If you provide only telemedicine for multiple locations, enter "Telemedicine" for the site name. Before completing, copy pages 3-5 for each site at which you practice.*

19. **Practice Name:** _____

Practice Phone: (_____) _____ - _____ **Extension**: _____

Practice <u>Physical</u> Street Address: _____

Practice City: _____ **Zip**:_____

Practice Mailing Address (if different): _____

Mailing Address City: _____ **Mailing Address Zip**:_____

20. **10-digit organizational NPI number** _____**No organizational NPI number** ☐
Note: If you do not know your NPI number, please visit https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do to locate it.

21. **Please identify (with an "x") the specialty(ies) that best define your practice, at this site**:
Specialty #1(Principal); Specialty #2 (Secondary); Specialty #3 (Tertiary)

Note: Your principal specialty is the specialty that you spend the most time practicing at this site.

Area of Practice	**Principal** (select one)	**Secondary** (select one, if applicable)	**Tertiary** (select one, if applicable)
Adolescent Medicine			
Anesthesiology			
Allergy and Immunology			
Cardiology			
Child Psychiatry			
Critical Care Medicine			
Dermatology			
Endocrinology			
Emergency Medicine			
Family Medicine/General Practice			
Gastroenterology			
Geriatric Medicine			
Gynecologic Oncology			
Gynecology Only			
Hematology & Oncology			
Hospital Medicine (Hospitalist)			
Infectious Diseases			
Internal Medicine (General)			
Nephrology			

Neurology			
Obstetrics and Gynecology			
Occupational Medicine			
Ophthalmology			
Otolaryngology			
Palliative Care			
Pathology			
Pediatrics (General)			
Pediatric Subspecialties			
Physical Med. & Rehab.			
Preventive Medicine/Public Health			
Psychiatry			
Pulmonology			
Radiation Oncology			
Radiology			
Rheumatology			
Surgery (General)			
Surgery – Subspecialties			
Colon and Rectal			
Neurological			
Orthopedic			
Other Surgical Specialties			
Plastic			
Thoracic			
Vascular			
Other			

22. **<u>Approximately</u> how many hours per week do you typically spend providing clinical services at this location?** *The hours should **<u>not</u** include time spent admitting, discharging, performing daily rounds on hospitalized patients, on-call, or on corporate/management activities **unless you are a Hospitalist**.*

_____hours/week

23. **Check the appropriate box below which best describes your work setting at this location**:

☐ Hospital/Inpatient/Surgical Center services only (hospitalist, pathology, radiology, ER, surgical center, etc.) *(skip the rest of the survey)*

☐ Extended/Institutional care only (nursing home/SNF, residential treatment, etc.) *(skip the rest of the survey)*

☐ Substance use disorder treatment centers *(skip the rest of the survey)*

☐ State/federal prison clinic *(skip the rest of the survey)*

☐ City/County correctional facility *(skip the rest of the survey)*

☐ Rehabilitation facility (OT/PT/ST) *(skip the rest of the survey)*

☐ Corporate/Educational Institution or Veterans Administration (VA) *(skip the rest of the survey)*

☐ Telemedicine *(skip the rest of the survey)*

☐ A non-traditional setting (e.g. home care, mobile services, etc.) *(skip the rest of the survey)*

☐ Other **NON-outpatient** setting *(skip the rest of the survey)*

☐ **Outpatient/Office-based setting** (none of the above describes this location)

24. **Is this location an outpatient/office facility <u>owned</u> by a hospital system?**
Note: Private/Stand-alone practices renting space from a hospital should answer 'No.'

☐ Yes ☐ No

25. **Does this location participate in any of the following federal programs?**
Note: Participation in these programs requires formal application and acceptance. Specific definitions apply. Please read the following before indicating participation in any of these programs:

<u>"Federally Qualified Health Center" (FQHC)</u> is an official federally designated status for non-profit organizations receiving ongoing federal grant support under Section 330 of the Public Health Service Act.
<u>"Rural Health Clinic" (RHC)</u> is an official federally designated status granted to specific primary care service delivery locations in rural areas. RHCs receive enhanced Medicaid and Medicare reimbursement. Do not indicate RHC status if you indicated participation in the FQHC program above.

☐ No federal program participation at this location
☐ Federally Qualified Health Center
☐ Federally certified Rural Health Clinic

26. **<u>Approximately</u> what percentage of the hours at this address are spent providing each of the following categories of care**: *(Total must equal 100%)*

a. Primary Medical Care _____%
Note: Primary care includes the initial assessment (first contact) and primary diagnosis of undifferentiated disease, primary treatment of acute conditions, and ongoing management of chronic illness. It also encompasses the performance of health promotion, disease prevention, health maintenance, counseling, and patient education activities, as well as advocating for the patient and coordinating the use of the entire health care system to benefit the patient. Specialties outside of <u>Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, and General Practice</u> are typically not considered to deliver primary medical care.

b. Specialty Care/Procedures _____%

c. Mental Health/Substance Abuse Care _____%
(not incidental to primary medical care)

27. **Do <u>you</u> accept <u>NH</u> Medicaid as a form of payment at this location (and accept payment from this payer)?**

☐ Yes ☐ No

28. **Is a formal sliding fee discount policy offered at this location?**
Note: Sliding fee discount policies (or sliding fee scales) are based upon federal poverty guidelines, and patient eligibility is determined by annual income and family size. These scales are established to ensure that a non-discriminatory, uniform, and reasonable charge is consistently and evenly applied. This does not include standard, discounted rates for everyone set by the facility or negotiated reductions granted on a case-by-case basis. There must be a sliding fee schedule posted in the waiting room.

☐ Yes ☐ No

28a. If yes, approximately what percentage of visits do you provide on a sliding fee discount basis?

_____%
(Enter a number between 1 and 100)

29. **Are you currently accepting new patients at this location?**

☐ Yes ☐ No ☐ N/A (not a primary location for patient intake from the general population)

30. **Are there routine (non-urgent) outpatient appointments set at this location?**

☐ Yes ☐ No

30a. **If yes, approximately what is the present wait for a routine appointment for:**

1) A new patient _____days *(Note: If new patients are not currently accepted, enter NA)*
2) An established patient _____days