

2023 Podiatrist License Renewal Survey Instrument

1. Sex
Dropdown List
 - a. Male
 - b. Female

2. Are you of Hispanic, Latina/o, or Spanish origin?
Yes/No Dropdown
 - 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. podiatrist license?
Dropdown List
 - a. Certificate
 - b. Associate degree
 - c. Bachelor's degree
 - d. Master's degree
 - e. Doctor of Podiatric Medicine

5. Where did you complete the podiatric education that first qualified you for your U.S. podiatrist license?
Dropdown 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 podiatric education that first qualified you for your U.S. podiatrist license? Please indicate using the four-digit year.

Text Box

7. If you have completed a residency, where did you complete your residency training?

Dropdown List

- a. No residency completed
- b. Indiana
- c. Michigan
- d. Illinois
- e. Kentucky
- f. Ohio
- g. Another State (not listed)
- h. Another Country (not U.S.)

8. If you have completed a residency, in which specialty was your residency program? If you did not complete a residency, please skip this question.

Multi Checkbox

- a. No residency completed
- b. Podiatric Medicine and Surgery Residency (PMSR)
- c. Podiatric Medicine and Surgery Residency with the added credential in Reconstructive Rearfoot/Ankle Surgery (PMSR/RRA)

9. What is your employment status?

Dropdown List

- a. Actively working in a position that requires a podiatrist license
- b. Actively working in a podiatric-related field that does not require a podiatrist license
- c. Actively working in a field that does not require a podiatrist license
- d. Not currently working, disabled
- e. Not currently working, seeking work in a position that requires a podiatrist license
- f. Not currently working, seeking work in a position that does not require a podiatrist license
- g. Student
- h. Leave of absence or Sabbatical
- i. Retired

10. What are your employment plans for the next 12 months?

Dropdown List

- a. Increase hours in the field of podiatry
- b. Decrease hours in the field of podiatry
- c. Leave employment in the field of podiatry and seek employment elsewhere
- d. Retire
- e. No planned change

11. How many weeks did you work as a podiatrist in the past year? Please approximate and enter a number 1 through 52 (no decimals).

Text Box

12. If your primary practice is located in Indiana, please provide the county in which it is located.

Text Box

13. Which best describes the type of setting that most closely corresponds to your primary direct patient care practice location:

Dropdown List

- a. Private or Group Medical Practice
- b. Health Maintenance Organization (HMO)
- c. Preferred Provider Organization (PPO)
- d. Hospital
- e. Long-Term Care/Extended Care Facility
- f. School Public Health Service
- g. Department of Veterans Affairs
- h. Armed Forces
- i. Municipal Health Department
- j. Health Profession School

14. Estimate the average number of hours per week spent at your primary practice location.

Dropdown List

- 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

15. Estimate the average number of hours per week spent in direct patient care at your primary practice location.

Dropdown List

- 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

5. Please indicate which of the following services you routinely provide or support as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.

CHECKBOXES

- a. Cancer screening
- b. Dementia/Alzheimer's care

- c. Diabetes screening
- d. Hepatitis C Treatment/Management
- e. High-risk pregnancy services
- f. HIV/AIDS Treatment/Management
- g. Labor and delivery services
- h. Obesity screening and/or counseling
- i. Post-natal services
- j. Pre-natal services
- k. Screening for substance use or behavioral health conditions (ex: SBIRT)
- l. Screening for high-risk pregnancy
- m. STD screening
- n. Tobacco use counseling
- o. None of the above

16. Please indicate the population groups to which you provide services:

CHECKBOXES

- a. Newborns
- b. Children (ages 2-10)
- c. Adolescents (ages 11-19)
- d. Adults
- e. Geriatrics (ages 65+)
- f. Pregnant women
- g. Inmates
- h. Disabled individuals
- i. Individuals in recovery
- j. Veterans
- k. Health Care Workers
- l. None of the above