2022 Respiratory Care Practitioner Re-Licensure Survey Instrument

1. Sex
   Dropdown List
   a. Female
   b. Male

1. Are you of Hispanic, Latina/o, or Spanish origin?
   RADIO BUTTONS
   a. Yes
   b. No

2. 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

2. Where did you complete the degree/credential that qualified you for your first U.S. respiratory care practitioner license?
   Dropdown List
   a. Indiana
   b. Michigan
   c. Illinois
   d. Kentucky
   e. Ohio
   f. Another State (not listed)
   g. Another Country (not U.S.)

3. What type of degree/credential qualified you for your first U.S. respiratory care practitioner license?
   Dropdown List
   a. Vocational/Practical Certificate
   b. Diploma
   c. Associate Degree
   d. Bachelor's Degree
   e. Master's Degree
   f. Doctoral Degree
   g. Military Training Certification
   h. Other

4. What year did you complete the respiratory care education that first qualified you for your U.S. respiratory care practitioner license? Please indicate using the four digit year.
   TEXT BOX

5. What is your highest earned degree/credential?

Dropdown List

a. Vocational/Practical Certificate
b. Diploma
c. Associate Degree
d. Bachelor's Degree
e. Master's Degree
f. Doctoral Degree
g. Military Training Certification
h. Other

6. Please select which credentials you have earned.
   Multi Checkbox
   a. None
   b. CRT (Certified Respiratory Therapist)
   c. RRT (Registered Respiratory Therapist)
   d. Neonatal/Pediatric Specialist
   e. CPFT (Certified Pulmonary Function Technologist)
   f. RPFT (Registered Pulmonary Function Technologist)
   g. R.EEG.T (Registered EEG Technologist)
   h. R.EP.T (Registered Electrophysiology Technologist)
   i. RPSGT (Registered Polysomnographic Technologist)
   j. CHT (Certified Hyperbaric Technologist)
   k. AE-C (Certified Asthma Educator)
   l. LVN (Licensed Vocational Nurse)
   m. RN (Registered Nurse)
   n. EMT (Emergency Medical Technician)
   o. Paramedic
   p. CCT (Certified Cardiographic Technician)
   q. Registered Cardiovascular Invasive Specialist
   r. CCM (Certified Case Manager)
   s. BCLS (Basic Cardiac Life Support)
   t. ACLS (Advanced Cardiac Life Support)
   u. PALS or APLS (Advanced Pediatric Life Support)
   v. NRP (Neonatal Resuscitation Protocol)
   w. BTLS (Basic Trauma Life Support)
   x. S.T.A.B.L.E.
   y. Other

7. What is your employment status?
   Dropdown List
   a. Actively working in the field of respiratory care
   b. Actively working in a field other than respiratory care
   c. Unemployed but seeking work in respiratory care
   d. Unemployed, not seeking work in respiratory care
   e. Retired

8. How many weeks did you work in respiratory care in the past year? Please approximate and enter a number 0 through 52 (no decimals).
   Text box

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

Dropdown List

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

10. Please indicate in which major activity you spend the majority of your time. If this does not apply, please select "not applicable."
    Dropdown List
    a. Not applicable
    b. Administration/management
    c. Direct patient care (includes hands-on care, documentation, and patient education)
    d. Indirect patient care (includes planning, consulting, assigning and teaching staff, evaluating care)
    e. Education of student RCPs
    f. Other

11. 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. Ventilator management
    b. Analyzing blood gases
    c. Responding to code blues
    d. Cancer screening
    e. Dementia/Alzheimer's care
    f. Diabetes screening
    g. Hepatitis C Treatment/Management
    h. High-risk pregnancy services
    i. HIV/AIDS Treatment/Management
    j. Labor and delivery services
    k. Obesity screening and/or counseling
    l. Post-natal services
    m. Pre-natal services
    n. Screening for substance use or behavioral health conditions (ex: SBIRT)
    o. Screening for high-risk pregnancy
    p. STD screening
    q. Tobacco use counseling
    r. None of the above

12. 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. None of the above

13. In how many locations do you provide respiratory care services?
Dropdown List
    a. 0
    b. 1
    c. 2
    d. 3
    e. 4 or more

14. Where is your primary practice (the location you spend the majority of your time as a respiratory care practitioner) located? If this does not apply, please select "not applicable."
Dropdown List
    a. Not applicable
    b. Indiana
    c. Michigan
    d. Illinois
    e. Kentucky
    f. Ohio
    g. Another State (not listed)
    h. Another Country (not U.S.)

15. If your primary practice is located in Indiana, please provide the county in which it is located. If this does not apply, please write "not applicable."
TEXT-BOX

16. Please identify the type of setting that most closely corresponds to your primary practice location. If this does not apply, please select "not applicable."
Dropdown List
    a. Not applicable
    b. Acute Care Hospital
    c. Durable Medical Equipment/Home Care
    d. Long-term Acute Care/Rehabilitation Hospital/Sub-Acute Care
    e. Skilled Nursing Facility
    f. Accredited Education Program
    g. Manufacturer/Distributer
    h. Outpatient Facility/Physician's Office
    i. Other

17. What is your primary specialty area of practice at your primary practice location? If this does not apply, please select "not applicable."
Dropdown List
    a. Not applicable
    b. Adult Critical Care
    c. Neonatal Critical Care
    d. Pediatric Critical Care
    e. Case Management
    f. Chronic Disease Management

g. Education
h. ECMO
i. Geriatrics
j. Home Care
k. Invasive Cardiology
l. Hyperbaric Medicine
m. Long-term Care
n. Polysomnography
o. Pulmonary Diagnostics
p. Pulmonary Rehabilitation
q. Rehabilitation
r. Transport
s. Trauma
t. Other

18. How many hours do you spend in direct care per week at this location? If this does not apply, please select "not applicable."
    Dropdown List
    a. Not applicable
    b. 0 hours per week
    c. 1 – 4 hours per week
    d. 5 – 8 hours per week
    e. 9 – 12 hours per week
    f. 13 – 16 hours per week
    g. 17 – 20 hours per week
    h. 21 – 24 hours per week
    i. 25 – 28 hours per week
    j. 29 – 32 hours per week
    k. 33 – 36 hours per week
    l. 37 – 40 hours per week
    m. 41 or more hours per week