

**Resident Name:** \_\_\_\_\_

**Staff Name:** \_\_\_\_\_

(Black out names after completion of ID check)

Form Approved

OMB No. 0935-XXXX

Exp. Date XX/XX/2010

# Collaborative Studies of Long-Term Care: Falls Prevention Program in Assisted Living

## C. Staff Interview (STF)

7-31-2007

Facility ID:

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Resident ID:

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Staff ID:

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Interviewer ID:

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Date  
completed:

M	M	D	D	Y	Y

Developed / adapted for the Collaborative Studies of Long-Term Care  
Cecil G. Sheps Center for Health Services Research  
University of North Carolina at Chapel Hill  
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Public reporting burden for this collection of information is estimated to average 10 minutes per response, the estimated time required to complete the survey. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 540 Gaither Road, Room # 5036, Rockville, MD 20850.

## Staff Information

1. What is your job title at this facility? <sub>1</sub> Direct care staff  
<sub>2</sub> Supervisor  
<sub>1</sub> Other (specify) \_\_\_\_\_

2. How long have you been in this current position? \_\_\_\_\_ years \_\_\_\_\_ months

3. How long have you worked at this facility? \_\_\_\_\_ years \_\_\_\_\_ months

4. What is your highest level of education completed? <sub>1</sub> Junior High or Middle School  
<sub>2</sub> Some high school  
<sub>3</sub> High school grad or GED  
<sub>3</sub> 2-year college or associate's degree  
<sub>4</sub> Some college (no degree)  
<sub>5</sub> 4-year college degree or higher

5a. Which of the following certifications or licensures do you hold?

<i>Check all that apply:</i>	
1. RN	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes
2. LPN	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes
3. CNA or Certified Personal Care Assistant	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes
4. Medication assistant	<input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>1</sub> Yes

6. What is your sex? [DO NOT ASK] <sub>1</sub> Male <sub>2</sub> Female

7. What year were you born? \_\_\_\_\_

8. Is English your first language? <sub>0</sub> No <sub>1</sub> Yes  
 If NO, what is: \_\_\_\_\_]

9. Are you Hispanic or Latino/Latina? <sub>0</sub> No <sub>1</sub> Yes  
*[code 7 for don't know; 8 for refusal]*

10. What is your race? Please select one or more?  
*[record all that the respondent identifies with; code 7 for don't know; 8 for refusal]*

<sub>1</sub> American Indian or Alaska Native  
<sub>2</sub> Asian  
<sub>3</sub> Native Hawaiian or Other Pacific Islander  
<sub>4</sub> Black or African American  
<sub>5</sub> White