PROGRAMMING INSTRUCTIONS APPEAR IN BLUE.

|  |
| --- |
| **SECTION 1: Demographics** |
|  | Are you male or female? |  | * Male
* Female
 |
|  |
|  | Do you consider yourself Latino or of Hispanic origin or descent? |  | * Yes, I am Latino/Hispanic/Spanish
* No, I am not Latino/Hispanic/Spanish
 |
|  |  |  |  |
|  | Which of the following categories describes your race? **Please ✓ all that apply.** |  | * White
* Black or African American
* Asian
* Native Hawaiian or other Pacific Islander
* American Indian or Alaskan Native
 |
|  |
|  | In what year were you born? |  | include drop down pick list of years from 1993 to 1935 (18 to 75 years of age) (use radio buttons) |
|  |
|  | Were you born in the USA? |  | * Yes, born in USA 🡺 Go to Question 7
* No, not born in USA
 |
|  |
|  | In what year did you first come to the USA? |  | Year you first came to USA: include drop down pick list of years from 2011 to 1935 (75 years) (use radio buttons) |
|  |
|  | In which of the following languages are you fluent?  **Please ✓ all that apply.** |  | * English
* Arabic
* Bengali
* Chinese
* French
* German
* Hindi
* Italian
* Japanese
* Korean
* Portuguese
* Russian
* Spanish
* Tagalog
* Urdu
* Vietnamese
* Other language (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |
|  | What is the highest education level you have completed? |  | * Less than grade 12
* Grade 12 (high school grad) or GED
* Vocational certificate
* Associate’s degree
* Bachelor’s degree
* Master’s degree
* Doctoral or professional degree (MD/DO, DDS/DMD, PhD, ScD, Pharm.D., etc.)
* Post doctoral education
 |
|  |
| **SECTION 2: Employment Status** |
|  |
| 1.
 | How many **employers** do you currently work for who provide healthcare or health-related services? (If you are self-employed, consider yourself the employer.) |  | * One
* Two
* Three
* More than three
 |
|  |

display question 10 on separate screen:

|  |
| --- |
| **If you work for more than one employer, the following questions apply to your *primary employer* i.e., the one for which you typically work the most hours. If you are self-employed, consider yourself the employer.** |
|  | Which of the following best describes your **employer**? **Ambulatory Health Care Services*** Physician office
* Dentist office
* Offices of other health practitioners (e.g., registered or licensed practical nurses, respiratory therapists, dental hygienists, chiropractors, optometrists, podiatrists)
* Outpatient care centers (e.g., freestanding ambulatory surgical centers and clinics, free standing emergency medical centers and clinics, HMO medical centers and clinics, dialysis centers, mental health and substance abuse centers)
* Medical laboratory
* Diagnostic imaging center (CT scan and MRI centers, X-ray labs)
* Blood/organ bank
* Home health care provider
* Other ambulatory health care facility

**Hospitals*** General medical and surgical hospital
* Psychiatric hospital
* Substance abuse hospital
* Specialty hospital (except psychiatric and substance abuse)

**Nursing and Residential Care Facilities*** Nursing care facility
* Residential mental retardation/mental health/substance abuse facility
* Community care facility for the elderly
* Other residential care facility

**Social Assistance/Services*** Individual and family services (includes home care) facility
* Community food and housing, emergency and other relief services
* Vocational rehabilitation facility
* Child day care facility

**Other** * (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

|  |
| --- |
|  |
| 1. .
 | Which of the following best describes your **current** occupation? **Please ✓ only one.**  |

display specialty after major catejory is selected

If Respondent marked any one of the nurse categories 🡺 Go to Question ; otherwise 🡺 Go to Question .

* Physician
* Primary care
* General surgery
* Physician Specialist(Please ✓ only one)
	+ Anesthesiologist
	+ Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Dentist or Other Dental Professional
* General Dentist
* Endodontist
* Oral and maxillofacial surgeon
* Orthodontist
* Pediatric dentist
* Periodontist
* Prosthodontist
* Dental hygienist
* Dental technician
* Dental assistant
* Other dental professional (Please specify): \_\_\_\_\_\_\_
* Pharmacist/Other Pharmacy Professional
* **P**harmacist
* Pharmacy technician
* Other pharmacy professional (Please specify): \_
* Therapist
* Respiratory Therapist
* Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Technologist or Technician
* Anesthesiologist Technician
* Central Supply/Processing Technician
* Dental Technician
* Echocardiology Technician
* EEG/Neuro Technician
* GI Lab Technician
* Pharmacy Technician
* Radiologic Technologist or Technician
* Sterilization technician
* Surgical Technologist
* Ultrasound Technician
* Other (Please specify):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Nurse
* AIDS care nurse
* Ambulatory care nurse
* Anesthetist (nurse)
* Cardiac rehabilitation nurse
* Case management
* Clinical nurse specialist/Nurse clinician
* Correctional nurse
* Director/CEO (nurse)
* Educator (nurse)
* Enterostomal therapy nurse
* Gastroenterology/Endoscopy nurse
* Genetics nurse
* General Nurse (no specialty)
* Home health nurse
* Hematology/Oncology nurse
* Infection control nurse
* Infusion/IV therapy nurse
* Long-term care nurse
* Managed care nurse
* Manager/administrator (nurse)
* Midwife (nurse)
* Nephrology nurse
* Neuroscience nurse
* Occupational health nurse
* Ophthalmic nurse
* OR Nurse
* Perioperative nurse
* Orthopaedic nurse
* Otorhinolaryngology nurse
* Pediatric nurse
* Perianesthesia nurse
* Perinatal nurse
* Primary care/Office nurse
* Psychiatric nurse
* Reconstructive surgical nurse
* Rehabilitation nurse
* Respiratory nurse
* School nurse
* Subacute care nurse
* Transplant nurse
* Trauma nurse
* Other nursing specialty (Please specify):
**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* Other HealthCare Professional
* Anesthesiologist assistant
* Home health aide
* Medical assistant
* Physician assistant
* Surgical assistant
* Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| display following note above questions 12-20:**If you work for more than one employer, please continue to think about your *primary employer* , i.e., the one for which you typically work the most hours. If you are self-employed, consider yourself the employer.** |
| 1.
 | Are you a staff nurse or an advanced practice nurse as defined by the different types of nursing licenses?   |  | * Staff Nurse (RN, LPN, LVN)
* Advanced Practice Nurse (NP, CRNA, CNS, CNM)
 |
|  |
| 1.
 | How much of your time is spent in direct patient care activities? |  | * 76-100%
* 51-75%
* 26-50%
* 1-25%
* No direct patient care
 |
|  |
| 1.
 | How long have you worked for your current employer? |  | * Less than 6 months
* At least 6 months but less than a year
* 1-5 years
* 6-10 years
* 11-20 years
* More than 20 years
 |
|  |
|  | How long have you worked as a {fill with current occupation as reported in Question 11}? |  | * Less than 6 months
* At least 6 months but less than a year
* 1-5 years
* 6-10 years
* 11-20 years
* 21- 30 years
* More than 30 years
 |
|  |
|  | How would you describe your work arrangement? |  | * + I am self-employed
	+ I am paid by a temporary agency
	+ I work for a contractor who provides services to others under contract
	+ I am a regular, permanent employee
	+ I am a student trainee
	+ I am an intern, resident or fellow
 |
|  |
|  | What is the total number of workers at your primary place of employment? |  | * Only myself
* 2-9 workers
* 10-99 workers
* 100-249 workers
* 250-1,000 workers
* More than 1,000 workers
 |
|  |
|  | Which of the following best characterizes your employer? |  | * For profit (individual, partnership or corporation)
* Non-profit or not-for-profit corporation
* City, county, district or state government (including public university-based)
* Federal government (e.g., military, VHA, IHS)
* Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |
|  | In what state do you work for your primary employer? |  | display drop down pick list of states (use radio buttons) |
|  |
| 1. .
 | Is your primary place of employment located in an urban, suburban or rural area? |  | * + Urban (large city; 50,000 people or more)
	+ Urban (small city; fewer than 50,000 people)
	+ Suburban (developed areas adjacent to cities)
	+ Rural (areas outside cities generally characterized by farms, ranches, small towns, and unpopulated regions)
 |
|  |  |  |  |
| 1.
 | Please check all of the locations where you worked in the past 7 calendar days.**Please ✓ all that apply.** For each respondent, randomize order of first three categories **Ambulatory Health Care Facilities*** Physician office
* Dentist office
* Offices of other health practitioners (e.g., registered or licensed practical nurses, respiratory therapists, dental hygienists, chiropractors, optometrists, podiatrists)
* Outpatient care centers (e.g., freestanding ambulatory surgical centers and clinics, free standing emergency medical centers and clinics, HMO medical centers and clinics, dialysis centers, mental health and substance abuse centers)
* Medical laboratory
* Diagnostic imaging center (CT scan and MRI centers, X-ray labs)
* Blood and organ banks
* Other ambulatory health care facility (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitals*** General medical and surgical hospital
* Psychiatric hospital
* Substance abuse hospital
* Specialty hospital (except psychiatric and substance abuse) (Please specify:\_\_\_\_\_\_\_\_\_\_)

**Nursing and Residential Care Facilities*** Nursing care facility
* Residential mental retardation, mental health and substance abuse facilities
* Community care facilities for the elderly
* Other residential care facilities (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other** * Homes of patients (including in-home hospice)
* Homeless shelter
* Emergency shelter
* Food bank (that provides health care services)
* Child day care facility
* Educational facility
* Correctional facility
* Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

|  |
| --- |
| display following note above questions 22-33:**If you work for more than one employer, please continue to think about your *primary employer,* i.e., the one for which you typically work the most hours. If you are self-employed, consider yourself the employer.** |
| 1. .
 | Are you a full-time or part-time employee? |  | * Full-time (typically 32 or more hours per week)
* Part-time (typically less than 32 hours per week)
 |
|  |
|  | How are you paid? |  | * + Salaried
	+ Paid by the hour
	+ Fee-for-service
* Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |
|  | Which of the following best describes the hours you usually work? |  | * Regular daytime shift or schedule(work anytime between 6am and 6pm)
* Regular evening shift(work anytime between 2 pm and midnight)
* Regular night shift(work anytime between 9pm and 8am)
* Regular shift plus periodic on-call
* Rotating shift(work shift that changes periodically from days to evenings or nights)
* Split shift(work shift consisting of two distinct work periods each day)
* Irregular shift/on call(unscheduled work arranged by the employer)
* Other schedule (Please specify):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
|  | Which of the following best describes your work schedule in a typical work week?  |  | * Weekdays only (Monday - Friday)
* Weekends only (Saturday and Sunday)
* Mix of weekdays and weekends
 |
|  |
|  | In the past 7 calendar days, how many days did you work?display calendar highlighting the past 7 calendar days. Applies to all questions with ‘in the past 7 calendar days’ |  | * 1 day
* 2 days
* 3 days
* 4 days
* 5 days
* 6 days
* 7 days
 |
|  |
|  | In the past 7 calendar days, what was the usual length of your work shift?  |  | * Less than 8 hours
* 8 hours
* 10 hours
* 12 hours
* More than 12 hours
* Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |
|  | In the past 7 calendar days, what was the total number of hours you worked? |  | Total number of hours worked: \_\_\_\_\_\_\_\_  |
|  |
|  | During the past 7 calendar days, did you work…  |  | * …more hours than usual
* …fewer hours than usual
* …about the same number of hours as usual
 |
|  |
|  | In the past 7 calendar days, did you work overtime (work done in addition to regular working hours)?  |  | * Yes
* No
 |
|  |
|  | Was the overtime mandatory (i.e., required by the employer)? |  | * Yes
* No
 |
| If Respondent reported working for more than one healthcare employer in Question 9 🡺 Go to Question 32. otherwise, 🡺 Go to Question 33. |
| 1.
 | Besides the {fill in answer from Question 28} hours you worked for your primary employer in the past 7 calendar days, what was the total number of hours you worked (paid or volunteer) for **any other** employers who provide healthcare or health-related services?  |  |  \_\_ \_\_hours |
|  |
| 1.
 | During the past 7 calendar days, how many hours did you work (paid or volunteer) for employerswho do **not** provide healthcare or health-related services?  |  | \_\_ \_\_hoursIf no other jobs, enter “0.” |

|  |  |
| --- | --- |
|  | To which of the following professional associations do you belong? **Please ✓ all that apply.** |
| * American Academy of Anesthesiologist Assistants (AAAA)
* American Association of Nurse Anesthetists (AANA)
* American Academy of Physician Assistants (AAPA)
* American Association of Pharmacy Technicians (AAPT)
* American Association for Respiratory Care (AARC)
* American Dental Association (ADA)
* American Dental Assistants Association (ADAA)
* American Dental Hygienists Association (ADHA)
* American Nurses Association (ANA)
* Association of periOperative Registered Nurses (AORN)
* Association of Pediatric Hematology/Oncology Nurses (APHON)
* American Society of Anesthesiologists (ASA)
* American Society of Perianesthesia Nurses (ASPAN)
* American Society of Health-System Pharmacists (ASHP)
* American Society of Radiologic Technicians (ASRT)
* Association of Surgical Technologists (AST)
* International Association of Healthcare Central Service Materiel Managers (IAHCSMM)
* Infusion Nurses Society (INS)
* National Pharmacy Technician Association (NPTA)
* National Surgical Assistants Association (NSAA)
* Oncology Nurses Society (ONS)
* Society of Gastroenterology Nurses and Associates (SGNA)
* Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  | Are you a member of a labor union?  |  | * Yes
* No
 |
|  |

|  |
| --- |
| **SECTION 3: Workplace Conditions**display following note above questions 36-50:**If you work for more than one employer, please continue to think about your *primary employer,* i.e., the one for which you typically work the most hours. If you are self-employed, consider yourself the employer.** |
| 36. | Are any of the following chemical agents used or present in the area(s) where you work? | Yes | No | I don’t know |
| a. Glutaraldehyde | 🔿 | 🔿 | 🔿 |
| b. Ortho-phthaldehyde | 🔿 | 🔿 | 🔿 |
| c. Formaldehyde | 🔿 | 🔿 | 🔿 |
| d. Nitrous oxide  | 🔿 | 🔿 | 🔿 |
| e. Anesthetic gases (other than nitrous oxide) | 🔿 | 🔿 | 🔿 |
| f. Antineoplastic agents (i.e., chemotherapeutic agents) | 🔿 | 🔿 | 🔿 |
| g. Pentamidine aerosol | 🔿 | 🔿 | 🔿 |
| h. Tobramycin aerosol  | 🔿 | 🔿 | 🔿 |
| i. Ribavirin aerosol | 🔿 | 🔿 | 🔿 |
| j. Surgical smoke | 🔿 | 🔿 | 🔿 |
| k. Ethylene oxide | 🔿 | 🔿 | 🔿 |
| l. Methyl methacrylate | 🔿 | 🔿 | 🔿 |
| if respondent marked ‘yes’ display appropriate follow-up question below. if respondent marked ‘no’ or ‘i don’t know’ to 36 a through l 🡺 Go to Question 38. |

|  |  |
| --- | --- |
| 37. | Please estimate the potential for exposure to the chemical agents used or present in your job. **Answer for what the exposure level would be if you did not wear personal protective equipment and protective clothing.** |
|  |  | No Exposure | Low Exposure | Medium Exposure | High Exposure | Unsure of Exposure |
| a. Glutaraldehyde  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| b. Ortho-phthaldehyde  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| c. Formaldehyde  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| d. Nitrous oxide  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| e. Anesthetic gases (other than nitrous oxide) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| f. Antineoplastic agents (i.e., chemotherapeutic agents) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| g. Pentamidine aerosol  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| h. Tobramycin aerosol  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| i. Ribavirin aerosol  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| j. Surgical smoke  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| k. Ethylene oxide (EtO) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| l. Methyl methacrylate  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 38. | Are any of the following present in the area(s) where you work? | Yes | No | I don’t know |
| a. Infectious diseases (e.g., Influenza, TB, HIV, HBV, HCV, MRSA, VRE) | 🔿 | 🔿 | 🔿 |
| b. Needles and other sharps | 🔿 | 🔿 | 🔿 |
| c. Non-ionizing radiation (e.g., UV, microwaves, radio-frequency, magnetic/electric fields, etc.) | 🔿 | 🔿 | 🔿 |
| d. Ionizing radiation (e.g., X-rays, gamma rays, etc.) (uses may include fluoroscopy, CT scans, radiosurgery, radioactive seeding, sterilization) | 🔿 | 🔿 | 🔿 |
| 1. Noise
 | 🔿 | 🔿 | 🔿 |
| f. Poor indoor air quality (e.g., molds, cigarette smoke, vehicle exhaust, etc.) | 🔿 | 🔿 | 🔿 |
| g. Machine safety hazards (e.g., exposed moving parts) | 🔿 | 🔿 | 🔿 |
| h. Temperature extremes | 🔿 | 🔿 | 🔿 |

if respondent marked ‘yes’ display appropriate follow-up question below.

if respondent marked ‘no’ or ‘i don’t know’ to 38 a through h 🡺 Go to Question 40.

|  |
| --- |
|  |
| 39. | Please estimate the potential for exposure to the hazards present in your job. **Answer for what the exposure level would be if you did not wear personal protective equipment and protective clothing, where applicable.** |
|  | No Exposure  | Low Exposure | Medium Exposure  | High Exposure  | Unsure of Exposure |
|  | a. Infectious diseases (e.g., Influenza, TB, HIV, HBV, HCV, MRSA, VRE) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| b. Needles and other sharps  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| c. Non-ionizing radiation (e.g., UV, microwaves, radio-frequency, magnetic/electric fields, etc.) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| d. Ionizing radiation (e.g., X-rays, gamma rays, etc.) (uses may include fluoroscopy, CT scans, radiosurgery, radioactive seeding, sterilization) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| e. Noise | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| f. Poor indoor air quality (e.g., molds, cigarette smoke, vehicle exhaust, etc.) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| g. Machine safety hazards (e.g., exposed moving parts) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| h. Temperature extremes | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |

|  |  |  |  |
| --- | --- | --- | --- |
| 40. | Are there any **other** health and safety hazards present in the area(s) where you work?   |  | * Yes
* No
 |

IF Respondent marked ‘No’ 🡺 Go to Question 42

|  |
| --- |
|  |
| 41. | Please list up to three other health and safety hazards and estimate the potential for exposure to each of them. **Answer for what the exposure level would be if you did not wear personal protective equipment and protective clothing, where applicable.** |
|  |  | No Exposure | Low Exposure | Medium Exposure | High Exposure | Unsure of Exposure |
|  | 1. (enter specific hazard) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| 2. (enter specific hazard) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| 3. (enter specific hazard)  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
|  |
| 42. | In the **past 12 months**, have you experienced a **work-related** injury, illness or exposure? |  | * Yes
* No 🡺 GO to Question 49
 |
| 43. | What was the nature of the **work-related** injury, illness or exposure? For each respondent, Randomize order of responses with exception of ‘Other’**Please ✓ all that apply.*** Laceration
* Wrist, arm or shoulder pain
* Back pain
* Slip, trip or fall
* Physical assault
* Needlesticks and other sharps injuries
* Asthma
* Breathing problems (other than asthma)
* Skin rash of hand(s), wrist(s) or forearm(s)
* Hearing problems
* Vision problems
* Body fluid exposure
* Infectious disease exposure
* Stress
* Exposure to chemicals (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other (Please specify up to 2 more)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| provide Respondent with questions 44 through 48 for each item checked in Question 43.  |
|  |
| 44. | Were you evaluated by a healthcare professional (e.g., physician, nurse, physical therapist, chiropractor) for the {fill in from Question 43}? |  | * Yes
* No
 |
|  |
| 45. | Were you off from work, even less than one day, as a result of the {fill in from Question 43}?  |  | * Yes
* No 🡺 Go to Question 47
 |
|  |
| 46. | How many calendar days were you off from work as a result of the {fill in from Question 43}?  |  | * Less than one day
* 1 day
* 2 days
* 3 days
* 4 to 7 days
* 8 or more days
 |
|  |
| 47. | How many calendar days were you on restricted (light) duty work as a result of the {fill in from Question 43}?  |  | * None
* 1-5 days
* 6-10 days
* 11-15 days
* 16-20 days
* More than 20 days
 |
|  |
| 48. | Did you receive workers’ compensation as a result of the {fill in from Question 43}? |  | * Yes
* No
* I don’t remember
 |
| **Workplace violence includes physical assaults, threats of assaults, harassment, intimidation or bullying. Sources may include patients, family members, visitors, and coworkers including supervisors.** |
|  |
| 49. | In the **past 12 months**, were you **verbally** threatened, intimidated or bullied while you were on the job? |  | * Yes
* No 🡺 Go to Question 50
 |
| 49a. | Who verbally threatened, intimidated or bullied you while you were on the job? **Please ✓ all that apply.** |  | * by co-worker
* by patient
* by other
 |
|  |
| 50. | In the **past 12 months**, were you **physically** assaulted or threatened while you were on the job? |  | * Yes
* No🡺 Go to Question 51
 |
|  |
| 50a. | Who physically assaulted or threatened you while you were on the job? **Please ✓ all that apply.** |  | * by co-worker
* by patient
* by other
 |

|  |
| --- |
| **SECTION 4: Physical Demands** |
| display following note above questions 51-55:**If you work for more than one employer, please continue to think about your primary employer, i.e., the one for which you typically work the most hours. If you are self-employed, consider yourself the employer.** |
| 51.  | Thinking about all of your job duties in the past 7 calendar days, how often did you… |
|  |  | Frequently | Sometimes | Rarely | Never |
| a. work for long periods (greater than 2 hours) with your head or arms in physically awkward positions? |  | 🔿 | 🔿 | 🔿 | 🔿 |
| b. reach above chest height? |  | 🔿 | 🔿 | 🔿 | 🔿 |
| c. squat or kneel ? |  | 🔿 | 🔿 | 🔿 | 🔿 |
| d. bend or twist wrists ? |  | 🔿 | 🔿 | 🔿 | 🔿 |
| e. make precise movements with your fingers? |  | 🔿 | 🔿 | 🔿 | 🔿 |
| f. work for long periods (greater than 2 hours) at a computer? |  | 🔿 | 🔿 | 🔿 | 🔿 |
| g. stand for long periods (greater than 2 hours)? |  | 🔿 | 🔿 | 🔿 | 🔿 |
|  |
| 52. | During a typical work week, how many times did you lift or move **patients** weighing **35 lbs** or more? | * Never 🡺 GO to Question 54
* 1-5 times
* 6-10 times
* 11-20 times
* 21-50 times
* More than 50 times
 |
|  |

| 53. | During a typical work week, how often did you use any of the following when lifting or transferring **patients** weighing **35 lbs** or more? skip 53f if respondent marked ‘only myself’ in question 17 |
| --- | --- |
|  | Always | Very Often | Sometimes  | Rarely | Never | Not Available |
|  | a. Lift or move by hand (unassisted) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |  |
| b. Fixed mechanical lifting devices such as ceiling lifts, floor lifts, sit-to-stand devices | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| c. Portable mechanical lift devices such as floor lifts, sit-to-stand devices, etc.  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| d. Slip or friction reduction devices such as slip sheets, roller or slider boards, air transfer devices, etc. | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| e. Gait belts (also called transfer belts) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| f. Lifting assistance from one or more co-workers (including designated lift teams) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| g. Any other assistive device (Please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 54. | During a typical work week, how many times did you lift or move **objects,** other than patients, weighing **50 lbs** or more? |  | * Never 🡺 GO to Question 56
* 1-5 times
* 6-10 times
* 11-20 times
* 21-50 times
* More than 50 times
 |
|  |

| 55. | During a typical work week, how often did you use any of the following when lifting or moving **objects**, other than patients, weighing **50 lbs** or more? Program to skip 55d, if R marked ‘only myself’ in Question 17 |
| --- | --- |
|  | Always | Very Often | Sometimes | Rarely | Never | Not Available |
| a. Lift or move by hand | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |  |
| b. Mechanical lifting devices (e.g., winch, dolly, forklift, etc.) | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| c. Roller or slider boards | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| d. Lifting assistance from one or more co-workers  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| e. Object is on wheels or casters  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| f. Any other assistive device (Please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |  |
|  |

|  |
| --- |
| **Section 5: Psychosocial Demands**display following note above questions 56-62:**If you work for more than one employer, please continue to think about your *primary employer,* i.e., the one for which you typically work the most hours. If you are self-employed, consider yourself the employer.** |
| 56. | How worried are you about becoming unemployed? |  | * Very worried
* Somewhat worried
* Not too worried
* Not at all worried
 |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| 57. | Do you feel discriminated against on your job for any of the following reasons?**Please ✓ all that apply.** |  | * Age
* Race or ethnic origin
* Gender
* Disability
* Job status or position
* Some other reason
* I don’t feel discriminated against on my job
 |
|  |
| 58. | Overall, how satisfied would you say you are with your job? |  | * Very satisfied
* Somewhat satisfied
* Not too satisfied
* Not at all satisfied
 |
|  |
| 59. | How much stress would you say you experienced **at work** in the past 7 calendar days? |  | * Almost no stress at all
* Moderate amount of stress
* A lot of stress
 |
|  |
| **Section 6: Personal Protective Equipment**  |
| 60. | During a typical work day, how many hours, on average, do you wear water-resistant gloves?**Water-resistent gloves include latex, vinyl, nitrile, butyl and other materials which are impervious to water.**  |  | * Less than 1 hour
* 1-2 hours
* 3-4 hours
* 5-6 hours
* 7-8 hours
* 9-10 hours
* 11-12 hours
* More than 12 hours
 |
|  |
| 61. | Is your primary place of employment latex-free? |  | * Yes 🡺 Go to Question 63
* No
* I don’t know
 |
|  |
| 62. | Are any of the protective gloves you wear during a typical work week made of **natural latex rubber**?display the three choices and “Please ✓ all that apply” after ‘yes’ is selected. |  | * Yes
* ‘powdered’
* ‘powder-free’
* ‘powder-free, low protein/allergen’
* No
* I don’t know
 |
|  |
| **SECTION 7: Seasonal Influenza** |
| display following note above questions 63-65: |
| **If you work for more than one employer, please continue to think about your *primary employer,*  i.e., the one for which you typically work the most hours. If you are self-employed, consider yourself the employer.** |
| skip questions 63 and 64, if Respondent checked ‘no direct patient care’ in Question 13. |
| 63. | Have you provided care to patients with seasonal flu or flu symptoms **in the last 12 months**?  |  | * Yes
* No 🡺 Go to Question 65
* I don’t know 🡺 Go to Question 65
 |
|  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| 64. | When caring for patients with seasonal flu or flu symptoms, which of the following do you wear?**Please** ✓ **all that apply.**  |
| * 200492754-001Standard surgical mask
 |  | * N95 respirator (includes

 surgical N95 respirator) Cup Style Surgical N95 Resp.jpgn95_duckbill2.jpg |
| * Half-facepiece air purifying respirator
 |  | * Full-facepiece air

Full facepiece APR.jpgpurifying respirator |
| * Powered air purifying

respirator (PAPR) PAPR.jpg.png |  | * Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  |
|  | * None of the above
 |  | * I don’t know
 |

 |
|  |
| 65. | Have you received a seasonal influenza vaccine in **the last 12 months**?  |  | * Yes
* No
 |

|  |
| --- |
| **SECTION 8: Hand Hygiene****If you work for more than one employer, please continue to think about your *primary employer,* i.e., the one for which you typically work the most hours. If you are self-employed, consider yourself the employer.** |
| 66. | During a typical work day, about how many times did you use any of the following hand sanitation or skin care products on your job?  | Never | 1-5times | 6-20times | 21-40times | More than 40times | Product notavailable |
| a. Alcohol-based hand sanitizer …………………. | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| b. Alcohol-free hand sanitizer…………………….. | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| c. Soap and water………………………………….. | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| d. Skin moisturizing lotion ………………………… | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| e. Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |  |
|  |
| **SECTION 9: Health and Safety Perceptions****If you work for more than one employer, please continue to think about your *primary employer,* i.e., the one for which you typically work the most hours. If you are self-employed, consider yourself the employer.**Repeat insructions and scale if greater than one web page  |
| 67. | Please indicate the level to which you agree or disagree with the following statements.For each respondent, randomize order of statements | Strongly Disagree | Disagree | Agree | StronglyAgree | Not Applicable |
| a. The health and safety of workers is a major priority for management | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| b. I feel safe from work-related injury or illness  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| c. I usually have enough time to take safety precautions while completing my duties | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| d. I feel free to express my concerns about health and safety conditions to management  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| e. Proper personal protective equipment is available to me | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| f. I am often required to do a task that makes me feel like I might be at risk of getting hurt | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| g. People working with me are frequently exposed to dangerous or risky situations  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| h. I feel managers and supervisors set proper examples by following safety rules and work practices  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| i. My work area is periodically inspected to identify potential health and safety hazards | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| j. Unsafe working conditions are corrected in a reasonable time period | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| k. I have received adequate training from my current employer to recognize health and safety hazards in my job  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| l. I feel that there is adequate staffing to perform my job duties | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| m. On my job. I have a lot of say in how I do my work  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| n. I can report injuries to my manager without worrying about how it will affect my job  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| o I can report injuries to my manager without worrying about how it will affect my department’s safety record  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| p. It is easy for me to combine work with family responsibilities  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| q. I feel my organization has a positive safety culture  | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
| r. Health and safety concerns influence my decision to continue working in the health care field | 🔿 | 🔿 | 🔿 | 🔿 | 🔿 |
|  |

Go to 2nd hazard module if indictated by screening module.

Otherwise, end survey with “thank you” statement

**Thank you for participating in the NIOSH Health and Safety Practices Survey of Healthcare Workers. Your answers have been submitted.**