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** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
|  | | 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.** | | | | | | | |
|  | 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) | | |
|  | | | | | | | |
|  | How much of your time is spent in direct patient care activities? |  | | | * 76-100% * 51-75% * 26-50% * 1-25% * No direct patient care | | |
|  | | | | | | | |
|  | 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) | |
|  | |  | |  | | |  | |
|  | | 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. | | | | | | | |
|  | 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 | |
|  | | | | | | | |
|  | 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? | | |  | | \_\_ \_\_hours  If 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 | | 1-5  times | 6-20  times | | 21-40  times | | More than 40  times | | Product  not  available |
| 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 | | Strongly Agree | | 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.**