Certification & Licensing

1. Are you currently board certified?

- ◯ Yes
- ◯ No

2. If yes, what board certifications do you maintain? Please check all that apply and add any specialty certifications as appropriate.

- ☐ Family Medicine - ABFM
- ☐ Family Medicine - AOA
- ☐ Internal Medicine - ABIM
- ☐ Internal Medicine - AOA
- ☐ Pediatrics - ABP
- ☐ Pediatrics - AOA
- ☐ OB/Gyn - ABOG
- ☐ OB/Gyn - AOA
- ☐ Psychiatry - ABPN
- ☐ Psychiatry - AOA
- ☐ General Dentistry - ABGP
- ☐ Pediatric Dentistry - ABPD

Other (please specify)

3. Do you currently hold an active medical or dental license?

- ◯ Yes
- ◯ No

4. If yes, in what state(s) do you hold an active license?

Currently in Training

5. Are you currently in a training position, such as a residency or fellowship?

- ◯ Yes
- ◯ No

Current Training Position

6. Please provide the following information for the training position:

Specialty of Program:

Training Institution Name:

City/Town:

State:

Country:

Additional Training

7. Have you completed any additional training, such as a residency or fellowship, since your primary care residency program?

- ◯ Yes
- ◯ No

Additional Training Positions

8. Please provide the following information for the most recent training position:

Specialty of Program:

Training Institution Name:

City/Town:

State:

Country:

9. Please provide the following information for the next most recent training position (if applicable):

Specialtyof Program:

Training Institution Name:

City/Town:

State:

Country:

10. Please provide the following information for the next most recent training position (if applicable):

Specialty of Program:

Training Institution Name:

City/Town:

State:

Country:

Post-Graduation Employment

11. Are you currently employed in a non-training position?

- ◯ Yes
- ◯ No

Post-Graduation Employment

12. If yes, how would you classify your current primary employer?

- ◯ Academic
- ◯ Private Practice
- ◯ Community Health Center
- ◯ Community-based organization/non-profit
- ◯ Hospital - Non-Academic
- ◯ Federal Government
- ◯ State Government
- ◯ City/County Government
- ◯ Unknown

Other (please specify)

Practicing Clinical Medicine/Dentistry

13. Are you currently practicing clinical medicine or dentistry?

- ◯ Yes
- ◯ No

Principal Clinical Practice Site

The following questions gather information about the sites where you practice clinically (i.e. provide patient care) - this may include seeing patients independently or with trainees, such as students or residents.

14. Please enter the following information for you PRINCIPAL practice site - this is the physical location where you spend most of your patient care time.

Name:

Address:

Address 2:

City/Town:

State:

ZIP:

Country:

15. What specialty do you primarily practice in this setting? Choose one.

- [ ] General Family Medicine
- [ ] General Internal Medicine
- [ ] General Pediatrics
- [ ] OB/Gyn
- [ ] Psychiatry
- [ ] Geriatrics
- [ ] Dentistry

Other (please specify)

16. What percent of a full-time equivalent (FTE) are you working at this site (Full-time =100%; Each half day per week is generally considered 10%)?

17. Which of the following best describes the principal method by which you are paid in this practice setting? Check one:

- ◯ Salary
- ◯ Receipts
- ◯ Base salary plus production incentive
- ◯ Locums

Other (please specify)

18. Which of the following best describes your principal practice setting's reimbursement model?

- ◯ Fee for service practice
- ◯ Health Maintenance Organization (HMO)
- ◯ Accountable Care Organization
- ◯ Concierge/Membership

Other (please specify)

19. Which of the following best describes your principal practice setting (check all that apply)?

- ☐ Community-based Health Center
- ☐ Private Practice
- ☐ Teaching program
- ☐ Hospital
- ☐ Emergency Medicine
- ☐ Urgent Care
- ☐ Military

Other (please specify)

20. Which of the following best describes the practice organization of your principal practice (check only one):

- ◯ Solo
- ◯ Partnership (2-physician practice)
- ◯ Single specialty group (3 or more physicians)
- ◯ Multi-specialty partnership or group
- ◯ Hospital owned
- ◯ Academic program

Other (please specify)

21. Does this practice site fall into any of the following federally designated areas/practices? Check all that apply.

- [ ] HPSA: Federally designated health professional shortage area
- [ ] MUA: Federally designated medically underserved area
- [ ] MHC: Federally designated migrant health center
- [ ] CHC: Federally designated community health center
- [ ] RHC: Federally designated rural health clinic
- [ ] NHSC: National Health Service Corps
- [ ] IHS: Indian Health Service site or tribal clinic
- [ ] FQHC: Federally Qualified Health Center
- [ ] State qualified health center/clinic
- [ ] State or Local Health Department
- [ ] None of the above

Other underserved population (please specify)

22. Please describe the ethnicity of your patient population at this site (approx):

% Hispanic or Latino	
% Not Hispanic or Latino	

23. Please describe the race of your patient population at this site (approx):

% American Indian or Alaska Native	
% Asian	
% Black or African-American	
% Native Hawaiian or Other Pacific Islander	
% White	

24. What is the approximate percent of patients who are on Medicaid in this practice?

- ◯ 0-9%
- ◯ 10-30%
- ◯ 31-50%
- ◯ 51-70%
- ◯ 71-90%
- ◯ 91-100%
- ◯ Don't know

25. What is the approximate percent of patients who are on Medicare in this practice?

- ◯ 0-9%
- ◯ 10-30%
- ◯ 31-50%
- ◯ 51-70%
- ◯ 71-90%
- ◯ 91-100%
- ◯ Don't know

26. What is the approximate percent of patients who are uninsured in this practice?

- ◯ 0-9%
- ◯ 10-30%
- ◯ 31-50%
- ◯ 51-70%
- ◯ 71-90%
- ◯ 91-100%
- ◯ Don't know

27. How many patients do you typically see in this practice setting during a half day of practice? (Please use an integer)

28. Are you providing patient care at any other sites?

- ◯ Yes
- ◯ No

Additional Clinical Site #1

29. Please enter the following information for the clinical site you spend the next most time in:

Name:

Address:

Address 2:

City/Town:

State:

ZIP:

Country:

30. What specialty do you primarily practice in this setting? Choose one.

- [ ] General Family Medicine
- [ ] General Internal Medicine
- [ ] General Pediatrics
- [ ] OB/Gyn
- [ ] Psychiatry
- [ ] Geriatrics
- [ ] Dentistry

Other (please specify)

31. Which of the following best describes this practice setting (check all that apply)?

- [ ] Community-based Health Center
- [ ] Private Practice
- [ ] Teaching program
- [ ] Hospital
- [ ] Emergency Medicine
- [ ] Urgent Care
- [ ] Military

Other (please specify)

32. Does this practice site fall into any of the following federally designated areas/practices? Check all that apply.

- [ ] HPSA: Federally designated health professional shortage area
- [ ] MUA: Federally designated medically underserved area
- [ ] MHC: Federally designated migrant health center
- [ ] CHC: Federally designated community health center
- [ ] RHC: Federally designated rural health clinic
- [ ] NHSC: National Health Service Corps
- [ ] IHS: Indian Health Service site or tribal clinic
- [ ] FQHC: Federally Qualified Health Center
- [ ] State qualified health center/clinic
- [ ] State or Local Health Department
- [ ] None of the above

Other underserved population (please specify)

33. What percent of a full-time equivalent (FTE) are you working at this site (Full-time =100%; Each half day per week is generally considered 10%)?

34. How many patients do you typically see in this practice setting during a half day of practice? (Please use an integer)

35. Are you providing patient care at any other sites?

- ◯ Yes
- ◯ No

Additional Clinical Site #2

36. Please enter the following information for the clinical site you spend the next most time in:

Name:

Address:

Address 2:

City/Town:

State:

ZIP:

Country:

37. What specialty do you primarily practice in this setting? Choose one.

- [ ] General Family Medicine
- [ ] General Internal Medicine
- [ ] General Pediatrics
- [ ] OB/Gyn
- [ ] Psychiatry
- [ ] Geriatrics
- [ ] Dentistry

Other (please specify)

38. Which of the following best describes this practice setting (check all that apply)?

- [ ] Community-based Health Center
- [ ] Private Practice
- [ ] Teaching program
- [ ] Hospital
- [ ] Emergency Medicine
- [ ] Urgent Care
- [ ] Military

Other (please specify)

39. Does this practice site fall into any of the following federally designated areas/practices? Check all that apply.

- [ ] HPSA: Federally designated health professional shortage area
- [ ] MUA: Federally designated medically underserved area
- [ ] MHC: Federally designated migrant health center
- [ ] CHC: Federally designated community health center
- [ ] RHC: Federally designated rural health clinic
- [ ] NHSC: National Health Service Corps
- [ ] IHS: Indian Health Service site or tribal clinic
- [ ] FQHC: Federally Qualified Health Center
- [ ] State qualified health center/clinic
- [ ] State or Local Health Department
- [ ] None of the above

Other underserved population (please specify)

40. What percent of a full-time equivalent (FTE) are you working at this site (Full-time =100%; Each half day per week is generally considered 10%)?

41. How many patients do you typically see in this practice setting during a half day of practice? (Please use an integer)

42. Are you providing patient care at any other sites?

- ◯ Yes
- ◯ No

Additional Clinical Site #3

43. Please enter the following information for the clinical site you spend the next most time in:

Name:

Address:

Address 2:

City/Town:

State:

ZIP:

Country:

44. What specialty do you primarily practice in this setting? Choose one.

- [ ] General Family Medicine
- [ ] General Internal Medicine
- [ ] General Pediatrics
- [ ] OB/Gyn
- [ ] Psychiatry
- [ ] Geriatrics
- [ ] Dentistry

Other (please specify)

45. Which of the following best describes this practice setting (check all that apply)?

- [ ] Community-based Health Center
- [ ] Private Practice
- [ ] Teaching program
- [ ] Hospital
- [ ] Emergency Medicine
- [ ] Urgent Care
- [ ] Military

Other (please specify)

46. Does this practice site fall into any of the following federally designated areas/practices? Check all that apply.

- [ ] HPSA: Federally designated health professional shortage area
- [ ] MUA: Federally designated medically underserved area
- [ ] MHC: Federally designated migrant health center
- [ ] CHC: Federally designated community health center
- [ ] RHC: Federally designated rural health clinic
- [ ] NHSC: National Health Service Corps
- [ ] IHS: Indian Health Service site or tribal clinic
- [ ] FQHC: Federally Qualified Health Center
- [ ] State qualified health center/clinic
- [ ] State or Local Health Department
- [ ] None of the above

Other underserved population (please specify)

47. What percent of a full-time equivalent (FTE) are you working at this site (Full-time =100%; Each half day per week is generally considered 10%)?

48. How many patients do you typically see in this practice setting during a half day of practice? (Please use an integer)

49. Are you providing patient care at any other sites?

- ◯ Yes
- ◯ No

Patient Encounters

50. On average, how many face-to-face patient encounters do you have per week in each of the following settings? (Please use an integer for each)

Office	
Hospital	
Nursing Home	
Home Visit	
Emergency Department	
Other (Specify setting and number)	

Non-Patient Care Time

51. Do you have time in your job reserved for non-patient care related activities (such as teaching, research or administration)?

- ◯ Yes
- ◯ No

52. If yes, please indicate what percent FTE, regardless of location, you are working in each of the following areas:

Teaching	
Research	
Administration	
Other (Please specify area and FTE)	

53. Are you currently involved in community service related to your position as a health care provider in the community? Examples might include working with a free clinic, conducting health outreach, or working with a local health related agency.

- ◯ Yes
- ◯ No

54. If yes, please describe how you are involved in community service related to your position as a health care provider in the community.

Non-Practicing

55. If you are not practicing clinical medicine or dentistry, what are you currently doing?

Previous Employment

56. Have you held any other jobs since graduating from your primary care residency?

- ◯ Yes
- ◯ No

Previous Employment

57. Please provide the following information for the most recent employment:

Specialty of Practice:

Organization:

City/Town:

State:

ZIP:

Country:

Start Date: (Month/Yr)

End Date: (Month/Yr)

58. How would you classify this employer?

- ◯ Academic
- ◯ Private Practice
- ◯ Community-based organization/non-profit
- ◯ Hospital - Non-Academic
- ◯ Federal Government
- ◯ State Government
- ◯ City/County Government
- ◯ Unknown

Other (please specify)

59. Please provide the following information for the next most recent employment (if applicable):

Specialty of Practice:

Organization:

City/Town:

State:

ZIP:

Country:

Start Date: (Month/Yr)

End Date: (Month/Yr)

60. How would you classify this employer?

- ◯ Academic
- ◯ Private Practice
- ◯ Community-based organization/non-profit
- ◯ Hospital - Non-Academic
- ◯ Federal Government
- ◯ State Government
- ◯ City/County Government
- ◯ Unknown

Other (please specify)

61. Please provide the following information for the next most recent employment (if applicable):

Specialty of Practice:

Organization:

City/Town:

State:

ZIP:

Country:

Start Date: (Month/Yr)

End Date: (Month/Yr)

62. How would you classify this employer?

- ◯ Academic
- ◯ Private Practice
- ◯ Community-based organization/non-profit
- ◯ Hospital - Non-Academic
- ◯ Federal Government
- ◯ State Government
- ◯ City/County Government
- ◯ Unknown

Other (please specify)

Loan Repayment

63. Have you participated in a loan repayment program since finishing your primary care residency?

- ◯ Yes
- ◯ No

64. If you have received any kind of loan repayment since completing your primary care residency program, please indicate the type of loan repayment program. Choose all that apply.

- ☐ Department of Education's Public Service Loan Forgiveness (PSLF)
- ☐ National Health Service Corps Scholarship
- ☐ National Health Service Corps Loan Repayment
- ☐ Indian Health Service Corps
- ☐ Armed Services (Navy, Army, Air Force)
- ☐ Uniformed Service (CDC, HHS)
- ☐ State loan forgiveness program
- ☐ Hospital program (e.g. sign-on bonus)

Other (please specify)

Contact Information

65. Please provide any updates in your contact information for your residency program:

Name:	
Address:	
Address 2:	
City/Town:	
State:	
ZIP:	
Country:	
Email Address:	
Phone Number:	

Comments

Thank you for completing this survey. Please provide any additional comments either in regard to the survey or to your residency program in the space below.

66. Comments