€ CASE € CONTROL

Form Approved
OMB No.0920-1013
Exp. Date 04/30/2017

Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

Attachment F: Community-associated *Clostridium difficile* Infection (CDI) Risk Factor Study

Adult Case and Control Interview

SECTION 1: IDENTIFIERS- CASES AND CONTROLS

1. € CASE € CONTROL
2. Study ID: _____

3. If Control, Reference date: _____/_____/_____

(mm/dd/yyyy)

2 weeks before _____/_____/_____

4 weeks before _____/_____/_____

12 weeks before _____/_____/_____

4. Age (years) €€€

5. Sex € Male € Female

€ CASE € CONTROL
Patient ID:_____
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SECTION 2: ILLNESS QUESTIONS- ****CASES ONLY ****CONTROLS SKIP TO SECTION 3, Q. 11**

Now I will ask you questions about your illness.

6. ***If yes,*** Do [you] remember when your diarrhea began around the time of (positive specimen date ____/_____/_____)?

Yes.....1 ***(If Yes –fill in date diarrhea began and use as reference date.)***
No.....2 ***(fill in date of specimen collection and use as reference date.)***
Don't know/Not sure.....7 ***(fill in date of specimen collection and use as reference date.)***
Refused.....9 ***(fill in date of specimen collection and use as reference date.)***

€ REFERENCE DATE: _____/_____/_____

(mm/dd/yyyy)

2 week before _____/_____/_____

€€€

7. How many days did your diarrhea last around that time? _____

Don't know/Not sure……7
Refused.....9

7A. On the worst day of your diarrhea that was occurring around the time of (reference date ____/_____/_____), what was the approximate number of stools you had in a 24-hour period?

≥3-<5 stools.....1
5-10 stools.....2
>10 stools.....3
Don't know/Not sure.....7
Refused.....9

8. Did you have any of the following symptoms associated with your *C. difficile* illness around the time of (reference date ____/_____/_____)?

[READ LIST]	Yes	No	DK/NS	Refused
Bloody stools	1	2	7	9
Fever	1	2	7	9
Nausea	1	2	7	9
Vomiting	1	2	7	9
Abdominal pain	1	2	7	9
Other	1	2		

Specify:_____

9. Were you hospitalized overnight for your *C. difficile* illness around the time of (reference date ____/_____/_____)?

Yes.....1
No.....2
Don't know/Not sure.....7
Refused.....9

9A. **If yes**, where:_____

(*name of hospital will not be transmitted to CDC)*

10. At the time of your *C. difficile* diagnosis around the time of (reference date ____/_____/_____), were you told by a doctor or healthcare provider that you had any other stomach [enteric, gastrointestinal] infection?

Yes.....1

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No.....2 ***(Go to Q.11)***
Don't know/Not sure.....7 ***(Go to Q.11)***
Refused.....9 ***(Go to Q.11)***

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Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

10A. ***If yes,*** what was the name of the infection?

[Read list if necessary]	Yes	No	DK/NS	Refused
Campylobacter	1	2	7	9
E. coli	1	2	7	9
Listeria	1	2	7	9
Salmonella	1	2	7	9
Shigella	1	2	7	9
Vibrio	1	2	7	9
Yersinia	1	2	7	9
Cryptosporidium	1	2	7	9
Giardia	1	2	7	9
Rotavirus	1	2	7	9
Norovirus	1	2	7	9
Other	1	2		

Specify:_____

SECTION 3: HEALTHCARE CONTACTS- CASES AND CONTROLS

Now I will ask you questions about your healthcare contacts between [12 weeks *before* [Reference Date_____/_____/_____] to [Reference Date_____/_____/_____].

11. Did you receive care in any doctor's office, dental office, hospital, or any other medical facility in the 12 weeks *before* [REFERENCE DATE_____/_____/_____]?

Yes.....1
No.....2 ***(Go to Q.12)***
Don't know/Not sure.....7 ***(Go to Q.12)***
Refused.....9 ***(Go to Q.12)***

11A. I will now ask you about the types of places you visited for your healthcare and when you made your visit**.** Did you visit any of the following places?

[READ LIST]	**YES=1**	**NO=2**	**DN/NS=7**	**Refuse=9**	**If yes, how many weeks prior to** [Reference Date_____/_____/_____] **did you visit this place?**		
					2 weeks	4 weeks	12 weeks
Outpatient Procedure center							
Ambulatory / Outpatient Surgery center							
Dental office							
Doctor's office							
Emergency department/Room							
Hemodialysis							
Hospital							
Outpatient lab							
Physical therapy center							
Urgent care							
Other (Specify)							

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REFERENCE Date _____/_____/_____
IF NO TO ALL OPTIONS IN Q.11A then SKIP to Q.12

11B. during those visits in the 12 weeks before (Reference Date_____/_____/_____) did you have any of the following procedures performed?

*****If Subject answered YES to dental visits only in 11A then only ask about last two items (oral surgery and dental cleaning)********

[READ LIST]	**YES=1**	**NO=2**	**DN/NS=7**	**Refuse=9**	**If yes, how many weeks prior to** [Reference Date_____/_____/____] **did you visit this place?**		
					2 weeks	4 weeks	12 weeks
Upper Endoscopy (Did the doctors pass a tube through your mouth or nose into your stomach?)							
Colonoscopy or Sigmoidoscopy (Did the doctors pass a tube into your rectum to look into your colon/bowel?)							
X-ray that required GI Prep (Did you have an X-ray performed where you had to swallow something first?)							
Chemotherapy							
Surgery in an operating room as an outpatient →**If yes, Specify type:**							
Other medical procedure (specify):							
Oral Surgery							
Dental Cleaning							

12. Did you visit a person in or go with anyone to a doctor's office, dental office, hospital, nursing home, or any other medical facility in the 12 weeks before [Reference Date_____/_____/_____]?

Yes.....1
No.....2 ***(Go to Q.13)***
Don't know/Not sure.....7 ***(Go to Q.13)***

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REFERENCE Date _____/_____/_____
Refused.....9 ***(Go to Q.13)***

12A. What type of facility did you visit or go with someone to in the 12 weeks before [Reference Date____/_____/_____]?

[READ LIST]	**YES=1**	**NO=2**	**DN/NS=7**	**Refuse=9**	**If yes, how many weeks prior to** [Reference Date_____/_____/____] **did you visit this place?**		
					2 weeks	4 weeks	12 weeks
Ambulatory / Outpatient procedure center							
Ambulatory / Outpatient surgery center							
Dental office							
Doctor's office							
Emergency department/Room							
Hemodialysis							
Hospital							
Long term care/ skilled nursing facility							
Outpatient lab							
Physical therapy center							
Urgent care							
Other (specify):							

SECTION 4: HOUSEHOLD CONTACTS

The next few questions are about you and persons who lived with you during the 12 weeks before [Reference Date_____/_____/_____].

13. How many people lived in your household including yourself during that time? € ***If answer is one (subject lives alone) skip to Q.20***

13A. What were the ages of your household members?? **[List number of people in each group]**

Ages € <1 € 1 to 3 € 4 to 10 € 11 to 17 € 18 to 34 € 35 to 59 € 60+

14. Did any household member excluding yourself wear diapers in the 12 weeks before (reference date ____/_____/_____)? (Including adults in diapers)
Yes.....1
No.....2
Don't know/Not sure.....7
Refused.....9

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REFERENCE Date _____/_____/_____

15. Did you have household members excluding yourself that attended a group childcare setting, daycare, or adult daycare in the 12 weeks before (reference date ____/_____/_____)? We consider daycare to be any place inside or outside your home where a household member spends at least 4 hours per week under an adult's care with at least two adults or children who did not live with you

Yes.....1
No.....2 (**Skip to Q 16)**
Don't know/Not sure.....7 (**Skip to Q 16)**
Refused.....9 (**Skip to Q 16)**

5A. ***If yes,*** what type(s) of daycare setting was it?**[*Read description of setting types if necessary***

Home……1

Center……..2

Members attend both types of daycare……..3

Don't know / Not Sure……..7

Refused…….9

Home – care is provided in someone's home typically by one person

Center- care is provided typically in a commercial building with many providers and rooms

16. In the 12 weeks before [Reference Date_____/_____/_____], did any household member stay overnight in a hospital?

Yes.....1
No.....2
Don't know/Not sure.....7
Refused.....9

17. In the 12 weeks before [Reference Date_____/_____/_____], did any household member stay overnight in a nursing home?

Yes.....1
No.....2
Don't know/Not sure.....7

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Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____
Refused.....9

18. In the 12 weeks before [Reference Date_____/_____/_____], did anyone else in your household have diarrhea?
Yes.....1
No.....2 ***(Go to Q.19)***
Don't know/Not sure.....7 ***(Go to Q.19)***
Refused.....9 ***(Go to Q.19)***

18A. ***If yes,*** did you assist this person with toileting (including diaper changes)?
Yes.....1
No.....2
Don't know/Not sure.....7
Refused.....9

18B. Was this person diagnosed with *C. difficile?*
Yes.....1
No.....2
Don't know/Not sure.....7
Refused.....9

19. Did any of your household members work or volunteer, in any capacity, at a hospital, other medical facility, or in any facility where patient care is provided in the 12 weeks before [Reference Date_____/_____/_____]? Volunteering can mean doing anything that requires you to enter a healthcare facility. Examples include: playing a musical instrument in the lobby, helping to direct patients to the correct area.
Yes.....1
No.....2 ***(Go to Q.20)***
Don't know/Not sure.....7 ***(Go to Q. 20)***
Refused.....9 ***(Go to Q.20)***

19A. ***If yes,*** what type of healthcare setting?

(READ LIST)	Yes	No	DK/NS	Refused
Hospital	1	2	7	9
Emergency department/room	1	2	7	9
Doctor's office	1	2	7	9
Dentist	1	2	7	9
Long term care (skilled nursing facility)	1	2	7	9
Hemodialysis facility	1	2	7	9
Other facility	1	2		

Specify:_____

19B. Did their job involve direct physical contact with the patients? For example, touching the patient to help her get out of a chair
Yes.....1
No.....2 ***(Go to Q.20)***
Don't know/Not sure.....7 ***(Go to Q. 20)***
Refused.....9 ***(Go to Q.20)***

19B1. ***If yes,*** what was their main job?

_____

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REFERENCE Date _____/_____/_____

19B2. Job Code €€-€€€€ ***(Fill in job code after interview is finished)***

20. Did you work or volunteer, in any capacity, at a hospital, other medical facility, or in any facility where patient care is provided in the 12 weeks before [Reference Date____/____/_____]? Volunteering can mean doing anything that requires you to enter a healthcare facility. Examples include: playing a musical instrument in the lobby, helping to direct patients to the correct area.

Yes.....1
No.....2 ***(Go to Q.21)***
Don't know/Not sure.....7 ***(Go to Q. 21)***
Refused.....9 ***(Go to Q.21)***

20A. ***If yes,*** what type of healthcare setting?

(READ LIST)	Yes	No	DK/NS	Refused
Hospital	1	2	7	9
Emergency department/room	1	2	7	9
Doctor's office	1	2	7	9
Dentist	1	2	7	9
Long term care (skilled nursing facility)	1	2	7	9
Hemodialysis facility	1	2	7	9
Other facility	1	2		

Specify:_____

20B. Did your job involve direct physical contact with the patients? For example, touching the patient to help her get out of a chair

Yes.....1
No.....2 ***(Go to Q.21)***
Don't know/Not sure.....7 ***(Go to Q. 21)***
Refused.....9 ***(Go to Q.21)***

20B1. ***If yes,*** what was your main job?

_____

20B2. Job Code €€-€€€€ ***(Fill in job code after interview is finished)***

SECTION 5: DIET EXPOSURES

I'd like to change direction now and ask you about the foods you generally eat in a given week and the kind of water you drink.

21. In a current typical week, not in the past timeframe we have talked about, how frequently do you consume the following foods?

[READ LIST]	Often	Sometimes	Rarely	Never	DK/NS	Refused
	>5/week	**2-5 /week**	**<2/ week**	**Never**		
Eggs	1	2	3	4	7	9
Dairy (milk, yogurt)	1	2	3	4	7	9

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State ID:_____

REFERENCE Date _____/_____/_____

Fresh raw Vegetables	1	2	3	4	7	9
Plant based protein (tofu, tempeh, seitan)	1	2	3	4	7	9
Red Meat (beef, lamb, pork, other game meat)	1	2	3	4	7	9
Poultry (chicken, turkey)	1	2	3	4	7	9
Seafood (fish, shellfish)	1	2	3	4	7	9

21.

22. Did you receive food / formula through a feeding tube called a G-tube or J-tube in the 12 weeks before [Reference Date____/____/_____]?

Yes.....1
No.....2
Don't know/Not sure.....7
Refused.....9

23. Which one of the following was the source of tap water in your home around the time of (reference date ____/_____/_____) (select only one):

☐ water utility ☐ private well ☐ spring ☐ unknown ☐ other

Name of the water utility, if known _____

If other, specify type and location _____

23A. At home, what type of unboiled water didyou most often use for drinking around the time of (reference date ____/_____/_____) (chose only one)?

_____ Tap water not treated in the home
_____ Tap water treated in the home (for example, filtered, UV light, distilled, or whole house point-of-entry device)
_____Commercially bottled water
_____Other _____

SECTION 6: MEDICAL HISTORY

The next sets of questions are about medications you may have been taking in the 12 weeks before [Reference Date____/____/_____]. Medicine bottles or records may help you remember about specific medications. Would you like to gather this information before we go on?

24. Did you take any antibiotics by mouth or in an I.V. (in your vein) in the 12 weeks before [Reference Date____/____/_____]?

Yes.....1
No.....2 ***(Go to Q.25)***
Don't know/Not sure.....7 ***(Go to Q.25)***
Refused.....9 ***(Go to Q.25)***

24A. Why did you take these antibiotic(s)? ***Note: Subjects may indicate more than one reason (For example, if more than one course of antibiotics was taken for different illnesses or if one antibiotic was taken for and ear infection and a pneumonia)***

[DO NOT READ LIST]	Yes	No
Acne	1	2

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State ID:_____

REFERENCE Date _____/_____/_____

Bronchitis/ pneumonia	1	2
Dental cleaning	1	2
Ear, sinus, upper respiratory infection	1	2
Eye infection	1	2
Oral surgery	1	2
Skin or soft tissue infection (abscess or cellulitis)	1	2
Surgery	1	2
Urinary tract infection	1	2
Urinary tract prophylaxis	1	2
Refused	9	9
Don't know/Not sure	7	7
Other	1	2
Specify:		

24B. Which antibiotic(s) did you take in the 12 weeks before [Reference Date_____/_____/_____]?

[DO NOT READ LIST]		***If yes,** how many weeks prior to [Reference Date_____/_____/_____] did you take this antibiotic?*		
	YES	**2 weeks**	**4 weeks**	**12 weeks**
Amoxicillin	1			
Amoxicillin/Clavulanate or Augmentin	1			
Ampicillin	1			
Azithromycin	1			
Cefaclor	1			
Cefadroxil	1			
Cefdinir	1			
Cefixime	1			
Cefuroxime	1			
Cefprozil	1			
Cephalexin or keflex	1			
Cephradine	1			
Ciprofloxacin or Cipro	1			
Clarithromycin	1			
Clindamycin	1			
Dapsone	1			
Doxycycline	1			
Erythromycin	1			
Erythromycin/sulfa	1			
Fosfomycin	1			
Levofloxacin or levaquin	1			
Metronidazole or flagyl	1			
Norfloxacin or Norflox	1			
Ofloxacin or Oflox	1			

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Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

Penicillin or Pen VK	1			
Tetracycline	1			
Trimethoprim/Sulfa or Bactrim, Septra	1			
Vancomycin	1			
Other antibiotic 1	1			
Specify other antibiotic 1	1			
Other antibiotic 2	1			
Specify other antibiotic 2	1			
Don't know/Not sure	7			
Refused	9			

25. Did you use any antibiotic eye drops or ointments in the 12 weeks before [Reference Date_____/_____/_____]?

Yes.....1
No.....2 ***(Go to Q.26)***
Don't know/Not sure.....7 ***(Go to Q.26)***
Refused.....9 ***(Go to Q.26)***

25 A. ***If yes,*** what was the name of the drop (**read list if necessary**)?

Polytrim (Polymyxin sulfate / TMP)……..1
Ciloxan (Ciprofloxacin)……..2
Ocuflox (Ofloxacin)……..3
Vigamox, Moxeza (Moxifloxacin) ……4
Other……..9
Specify : _____

26. In the 12 weeks before [Reference Date_____/_____/_____], did you regularly take any acid-reducing medications to treat excessive stomach acid, heartburn, or gastroesophageal reflux disease (GERD)? We define regular use as use of the product at least 3 days per week. Such medications might include Tums, Prevacid, Maalox, Mylanta, Tagamet, Zantac, Prilosec, or Nexium.

Yes.....1
No.....2 ***(Go to Q.27)***
Don't know/Not sure.....7 ***(Go to Q.27)***
Refused.....9 ***(Go to Q.27)***

26A. ***If Yes*****,** please specify which medicine you regularly took in the 12 weeks before [Reference Date_____/_____/_____]

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REFERENCE Date _____/_____/_____

[DO NOT READ LIST]	**YES=1**	**NO=2**	**If yes, How many weeks prior to** (Reference Date_____/_____/_____) **did you take this medication?**		
			2 weeks	4 weeks	12 weeks
Aciphex/rabeprazole	1	2			
Alka-Seltzer	1	2			
Maalox	1	2			
Mylanta	1	2			
Nexium/esomeprazole	1	2			
Pepcid/famotidine	1	2			
Prevacid/lansoprazole	1	2			
Prilosec/omeprazole	1	2			
Protonix/pantoprazole	1	2			
Rolaids	1	2			
Tums	1	2			
Tagamet/cimetidine	1	2			
Zantac/ranitidine	1	2			
Other:	1	2			
Don't know/Not sure	7	7			
Refuse	9	9			

If yes, in the

2

weeks before

. These reasons include things like chronic pain, depression, anxiety, to stop smoking, and to help sleep. Examples of these medications include: Prozac, Celexa, Remeron, Paxil, and Trazadone.

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REFERENCE Date _____/_____/_____
27. In the 12 weeks before [Reference Date_____/_____/_____], did you regularly take any such medications? We define regular use as use of the product at least 3 days per week.

Yes.....1
No.....2 ***(Go to Q.28)***
Don't know/Not sure.....7 ***(Go to Q.28)***
Refused.....9 ***(Go to Q.28)***

€ CASE € CONTROL
Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

27A. ***If Yes,*** *please specify which medicine you regularly took in the 12 weeks before [Reference Date_____/_____/_____]*

[DO NOT READ LIST]			**If yes, How many weeks prior to** (Reference Date_____/_____/_____) **did you take this medication?**		
	YES	**NO**	2 weeks	4 weeks	12 weeks
Amitriptyline	1	2			
Anafranil (Clomipramine)	1	2			
Asendin (Amoxapine)	1	2			
Celexa, Cipramil (Citalopram)	1	2			
Cymbalta (Duloxetine)	1	2			
Effexor (Venlafaxine)	1	2			
Eldepryl, Emsam, Zelapar (Selegiline)	1	2			
Escitalopram	1	2			
Limbitrol (Chlordiazepoxide/Amitriptyline)	1	2			
Ludiomil,(Maprotiline)	1	2			
Luvox (Fluvoxamine)	1	2			
Marplan, (Isocarboxazid)	1	2			
Nardil, Nardelzine (Phenelzine sulfate)	1	2			
Norpramin (Desipramine)	1	2			
Nortriptyline	1	2			
Parnate,(Tranylcypromine)	1	2			
Paxil (Paroxetine)	1	2			
Pristiq (Desvenlafaxine)	1	2			
Prozac, Sarafem, Fontex (Fluoxetine)	1	2			
Remeron, Avanza, Zispin (Mirtazapine)	1	2			
Savella, (Milnacipran)	1	2			
Serzone, (Nefazodone)	1	2			
Silenor, Prudoxin, Zonalon (Doxepin)	1	2			
Surmontil (Trimipramine)	1	2			
Symbyax (Olanzapine/fluoxetine)	1	2			
Tofranil, (Imipramine)	1	2			
Trazadone	1	2			
Triptafen (amitriptyline/perphenazine)	1	2			
Viibryd (Vilazodone)	1	2			
Vivactil, (Protriptyline)	1	2			
Wellbutrin, Zyban (Bupropion)	1	2			
Zoloft, Lustral (Sertraline)	1	2			
Other (specify):___	1	2			
Don't know/Not Sure	7	7			
Refuse	9	9			

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Patient ID:_____
State ID:_____

REFERENCE Date _____/_____/_____

Now I am going to ask you about medical conditions you may have had.

28. **Prior to** [Reference Date_____/_____/_____], were you told by a medical provider that you had any of the following medical conditions?
[READ LIST – including information in parentheses]

READ LIST	Yes	No	DK/NS	Refused
Diabetes				
Heart attack				
Congestive heart failure				
Stroke				
High blood pressure				
Peripheral vascular disease (intermittent claudication, gangrene, peripheral arterial bypass)				
Chronic renal (kidney) failure				
⟶**If yes,** are you on dialysis or awaiting dialysis?				
Chronic lung disease (COPD, emphysema)				
Asthma				
Cystic fibrosis				
Chronic Hepatitis B infection				
Chronic Hepatitis C infection				
Organ transplant				
Bone marrow transplant				
Leukemia or lymphoma				
Sickle cell disease (not sickle cell trait)				
Solid tumor cancer (e.g. bone, liver, brain)				
Short gut disease (bowel/ intestinal insufficiency				
Inflammatory bowel disease (Crohn's disease, Ulcerative colitis)				
Lupus				
Rheumatoid arthritis				
Depression				
Other illness (specify)				

29. What is your current height and Weight?
Height:_____Ft_____in or _____cm
Weight: _____lbs or _____ Kg
Don't Know/ Not Sure….7
Refused ……..9

SECTION 8: DEMOGRAPHICS

Now I would like to ask you a few final questions.

30. Do you consider yourself to be? **[Read responses 1 & 2]**
___1 Hispanic or Latino
___2 Not Hispanic or Latino
___7 Don't Know/Not Sure (DO NOT READ)
___9 Refused (DO NOT READ)
___10 Other racial category (DO NOT READ)

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REFERENCE Date _____/_____/_____

31. I am going to read a list of racial categories. Which one or more of the following do you consider yourself to be…? **[Read responses 1-5 and allow respondent to select one or more]**

___1 White/Caucasian
___2 Black or African-American
___3 American Indian or Alaska Native
___4 Native Hawaiian or Other Pacific Islander
___5 Asian
___7 Don't Know/Not Sure (DO NOT READ)
___9 Refused (DO NOT READ)
___10. Other racial category (DO NOT READ)

32. What is your occupation? _____

33. What was your main type of health care coverage during 12 weeks before [Reference Date_____/_____/_____] ***I'm going to read all the choices***.

Private insurance, such as an HMO, PPO or a managed care plan	1
Public insurance, such as Medicaid, Medicare or state assistance program	2
A combination of private and public insurance	3
No health insurance	4
DO NOT READ: Other [specify] _____	8
Don't know/Not sure	7
Refused	9

34. What is the highest grade or year of school you completed?

___1 Never attended school or kindergarten only
___2 Elementary or middle school; 1st-8th grade
___3 Some high school; 9th-11th grade
___4 High school graduate; 12th grade or GED
___5 College or technical school for 1-3 years
___6 College for 4 years, with or without a degree
___9 Refused

35. In your home, what is the annual gross household income from all sources, including social security and pensions? ***READ EACH RESPONSE IN ORDER UNTIL RESPONDENT AGREES***.

___0 Dependent college student
___1 Less than $15,000 ___5 Less than $70,000
___2 Less than $25,000 ___6 $70,000 or more
___3 Less than $35,000 ___7 Don't know or not sure
___4 Less than $50,000 ___9 Refused

That was my last interview question. Thank you very much for your time and participation!

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36. Comments:

_____

_____

_____

_____

_____

37. Interview Completed? € Yes € No

38. Date of interview: ____/____/_____
(mm/dd/yyyy)

39. Interviewer initials: _____

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State ID:_____

REFERENCE Date _____/_____/_____

Health Interview Appendix—Job Codes

OFFICE OF MANAGEMENT AND BUDGET - 1998 Standard Occupational Classification

29-0000 Healthcare Practitioners and Technical Occupations
- 29-1000 Health Diagnosing and Treating Practitioners
  - 29-1010 Chiropractors
  - 29-1020 Dentists
    - 29-1021 Dentists, General
    - 29-1022 Oral and Maxillofacial Surgeons
    - 29-1023 Orthodontists
    - 29-1024 Prosthodontists
    - 29-1029 Dentists, All Other Specialists
  - 29-1030 Dietitians and Nutritionists
  - 29-1040 Optometrists
  - 29-1050 Pharmacists
  - 29-1060 Physicians and Surgeons
    - 29-1061 Anesthesiologists
    - 29-1062 Family and General Practitioners
    - 29-1063 Internists, General
    - 29-1064 Obstetricians and Gynecologists
    - 29-1065 Pediatricians, General
    - 29-1066 Psychiatrists
    - 29-1067 Surgeons
    - 29-1069 Physicians and Surgeons, All Other
  - 29-1070 Physician Assistants
  - 29-1080 Podiatrists
  - 29-1110 Registered Nurses
  - 29-1120 Therapists
    - 29-1121 Audiologists
    - 29-1122 Occupational Therapists
    - 29-1123 Physical Therapists
    - 29-1124 Radiation Therapists
    - 29-1125 Recreational Therapists
    - 29-1126 Respiratory Therapists
    - 29-1127 Speech-Language Pathologists
    - 29-1129 Therapists, All Other
  - 29-1130 Veterinarians
  - 29-1190 Miscellaneous Health Diagnosing and Treating Practitioners
    - 29-1199 Health Diagnosing and Treating Practitioners, All Other
- 29-2000 Health Technologists and Technicians
  - 29-2010 Clinical Laboratory Technologists and Technicians
    - 29-2011 Medical and Clinical Laboratory Technologists
    - 29-2012 Medical and Clinical Laboratory Technicians
  - 29-2020 Dental Hygienists
  - 29-2030 Diagnostic Related Technologists and Technicians
    - 29-2031 Cardiovascular Technologists and Technicians
    - 29-2032 Diagnostic Medical Sonographers
    - 29-2033 Nuclear Medicine Technologists
    - 29-2034 Radiologic Technologists and Technicians
  - 29-2040 Emergency Medical Technicians and Paramedics
  - 29-2050 Health Diagnosing and Treating Practitioner Support Technicians
    - 29-2051 Dietetic Technicians
    - 29-2052 Pharmacy Technicians
    - 29-2053 Psychiatric Technicians

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29-2054 Respiratory Therapy Technicians
29-2055 Surgical Technologists
29-2056 Veterinary Technologists and Technicians
29-2060 Licensed Practical and Licensed Vocational Nurses
29-2070 Medical Records and Health Information Technicians
29-2080 Opticians, Dispensing
29-2090 Miscellaneous Health Technologists and Technicians
29-2091 Orthotists and Prosthetists
29-2099 Health Technologists and Technicians, All Other
29-9000 Other Healthcare Practitioners and Technical Occupations
29-9010 Occupational Health and Safety Specialists and Technicians
29-9011 Occupational Health and Safety Specialists
29-9012 Occupational Health and Safety Technicians
29-9090 Miscellaneous Health Practitioners and Technical Workers
29-9091 Athletic Trainers
29-9099 Healthcare Practitioners and Technical Workers, All Other
31-0000 Healthcare Support Occupations
31-1000 Nursing, Psychiatric, and Home Health Aides
31-1010 Nursing, Psychiatric, and Home Health Aides
31-1011 Home Health Aides
31-1012 Nursing Aides, Orderlies, and Attendants
31-1013 Psychiatric Aides
31-2000 Occupational and Physical Therapist Assistants and Aides
31-2010 Occupational Therapist Assistants and Aides
31-2011 Occupational Therapist Assistants
31-2012 Occupational Therapist Aides
31-2020 Physical Therapist Assistants and Aides
31-2021 Physical Therapist Assistants
31-2022 Physical Therapist Aides
31-9000 Other Healthcare Support Occupations
31-9010 Massage Therapists
31-9090 Miscellaneous Healthcare Support Occupations
31-9091 Dental Assistants
31-9092 Medical Assistants
31-9093 Medical Equipment Preparers
31-9094 Medical Transcriptionists
31-9095 Pharmacy Aides
31-9096 Veterinary Assistants and Laboratory Animal Caretakers
31-9099 Healthcare Support Workers, All Other