

Appendix E. Non-respondent Survey Questionnaire

ID

Form Approved
OMB No. 0920-XXXX
Expires XX/XX/XXXX

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

School Questionnaire

The National Institute for Occupational Safety and Health (NIOSH) recently conducted an on-line health questionnaire of employees in your school district. We are asking a random sample of people who did not participate in this questionnaire to answer a short health questionnaire. This should only take a few minutes to complete. All responses are considered confidential in accordance with the Privacy Act of 1974 (Public Law 93-579). Please return the completed questionnaire in the enclosed postage-paid envelope. Thank you for your consideration in taking part in this survey.

“BY COMPLETING THIS QUESTIONNAIRE, YOU INDICATE YOUR CONSENT TO PARTICIPATE IN THIS STUDY.”

Reasons for Non-Response

1. We are trying to better understand why people decide to participate or not participate in health surveys. Can you please tell us the main reason why you declined to complete your health survey? *(select the option that most applies)*

- Not interested in topic
- Survey is too long and/or too busy to complete
- Don't like sharing information on topic
- Dislike or choose not to participate in surveys
- Distrust how information will be used
- Would like to be compensated for time
- Does not support government research
- Concerned about confidentiality/privacy
- Other (Please specify _____)

Respiratory Symptoms

2. In the past 12 months have you had....

Symptom	Yes	No
A. Wheezing or whistling in your chest?		
B. Chest tightness?		
C. Attacks of shortness of breath?		
D. Attacks of cough?		
E. Awakened by an attack of breathing difficulty?		

If YES to any of 2A, B, C, D, or E:

2.1 When you were away from school on weekends, days off, or vacations, are the

symptoms:

___ Same ___ Worse ___ Better

Asthma

3. Has a physician ever told you that you have asthma? Yes___ No___

IF YES:

3A. Date of asthma diagnosis:

___/___/___
(Mo.) (Year)

Demographics

4. Year of Birth: ___ ___ ___

5. Gender: ___ Male
___ Female

6. Ethnicity (Please choose one):
___ Hispanic or Latino
___ Not Hispanic or Latino

7. Race (Please choose all that apply):
___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Other Pacific Islander
___ White

Job Information

8. Please indicate your current job title:
___ Teacher
___ Teacher's Aide/Assistant
___ School Administration
___ Office Staff
___ School Engineer
___ Maintenance
___ Custodian/Janitorial/Cleaning
___ Medical Staff
___ Library Staff
___ Counselor
___ Security
___ Cafeteria/Kitchen Worker
___ Other (specify_____)

Smoking History

9 Have you ever smoked cigarettes regularly? Yes No
(Please mark "No" if you have smoked less than 100 cigarettes in your lifetime.)

IF YES:

9.1 Do you still smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No

THANK YOU FOR YOUR TIME!

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).