

Attachment B2: Screening Instrument for Health Care Providers

Public reporting burden of this collection of information is estimated to average 3 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0572).

1. Which of the following are you certified/credentialed as:
 - Medical doctor (MD)
 - Doctor of Osteopathic Medicine (DO)
 - Nurse Practitioner (NP)
 - Physician's Assistant (PA)
 - Other [terminate]

2. What is your medical specialty?
 - Family Medicine
 - Primary Care
 - Internal Medicine
 - Obstetrics - Gynecology
 - Other [terminate]

3. Are you board-certified or board-eligible in your specialty?
_____ Yes
_____ NO [terminate]

4. Is your work primarily in
 - a private practice (*this could include seeing private practice patients in a hospital setting*)
 - a public clinic
 - a managed care/HMO practice
 - a hospital [terminate]
 - other [terminate]

5. Approximately what percentage of your time do you spend in direct contact with patients?
 - 50% or more
 - Less than 50% [terminate]

6. In a typical week, do you generally provide care for 10 or more women age 18-45?
_____ Yes
_____ NO [terminate]

7. How many years have you been in practice?

8. Which professional organizations do you belong to?
 - € The American Congress of Obstetricians and Gynecologists
 - € American Academy of Family Physicians
 - € American Medical Association

- American College of Physicians
- American Academy of Nurse Practitioners
- American Academy of Physician Assistants
- Other (please describe)
- None

9. Gender: (1a)

- Male
- Female

10. In what zip code do you currently practice medicine? ENTER FIVE DIGIT ZIP CODE. (9a.)

11. Please select any of the following you use to describe yourself. (You may select more than one)

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

12. Are you Hispanic or Latina?

- Yes
- No

13. Are you of Ashkenazi Jewish descent?

- Yes
- No