



Healthcare Worker Demographic Data

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*required for saving

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| Facility ID#: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *HCW ID#: | Social Security #: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Secondary ID#: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HSW Name, Last: | First: | Middle: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Street Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City: | State: | Zip Code: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Phone: () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other | | *Date of Birth: ____ / ____ / ____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Born in U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Not Latino | | Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employment Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Work Phone: () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Start Date: ____ / ____ / ____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> No longer affiliated | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Type of employee: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Contract employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Other (specify) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Work Location: | Department: | Supervisor: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Occupation: | Title: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If occupation is physician, indicate clinical specialty (check one): <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> ANE – Anesthesiology</td> <td><input type="checkbox"/> NRS – Neurosurgery</td> </tr> <tr> <td><input type="checkbox"/> CAR – Cardiology</td> <td><input type="checkbox"/> OBG – Obstetrics and Gynecology</td> </tr> <tr> <td><input type="checkbox"/> CTS – Cardiothoracic Surgery</td> <td><input type="checkbox"/> OPT – Ophthalmology</td> </tr> <tr> <td><input type="checkbox"/> CRC – Critical Care</td> <td><input type="checkbox"/> ORT – Orthopedics</td> </tr> <tr> <td><input type="checkbox"/> DOS – Dentistry/Oral Surgery</td> <td><input type="checkbox"/> OSS – Other Surgical Specialty</td> </tr> <tr> <td><input type="checkbox"/> DER – Dermatology</td> <td><input type="checkbox"/> OTH – Other Clinical Specialty</td> </tr> <tr> <td><input type="checkbox"/> ENT – Ear, Nose and Throat</td> <td><input type="checkbox"/> PAT – Pathology</td> </tr> <tr> <td><input type="checkbox"/> ERM – Emergency Medicine</td> <td><input type="checkbox"/> PED – Pediatrics</td> </tr> <tr> <td><input type="checkbox"/> FAP – Family Practice</td> <td><input type="checkbox"/> PLS – Plastic Surgery</td> </tr> <tr> <td><input type="checkbox"/> GAS – Gastroenterology</td> <td><input type="checkbox"/> PMR – Physical Medicine/Rehab</td> </tr> <tr> <td><input type="checkbox"/> GEN – General Surgery/Trauma</td> <td><input type="checkbox"/> PSC – Psychiatry</td> </tr> <tr> <td><input type="checkbox"/> IND – Infectious Diseases</td> <td><input type="checkbox"/> PUL – Pulmonology</td> </tr> <tr> <td><input type="checkbox"/> INM – Internal Medicine</td> <td><input type="checkbox"/> RAD – Radiology</td> </tr> <tr> <td><input type="checkbox"/> MSU – Other Medical Subspecialty</td> <td><input type="checkbox"/> URO – Urology</td> </tr> <tr> <td><input type="checkbox"/> NEP – Nephrology</td> <td><input type="checkbox"/> VAS – Vascular Surgery</td> </tr> <tr> <td><input type="checkbox"/> NEU – Neurology</td> <td></td> </tr> </table> | | | <input type="checkbox"/> ANE – Anesthesiology | <input type="checkbox"/> NRS – Neurosurgery | <input type="checkbox"/> CAR – Cardiology | <input type="checkbox"/> OBG – Obstetrics and Gynecology | <input type="checkbox"/> CTS – Cardiothoracic Surgery | <input type="checkbox"/> OPT – Ophthalmology | <input type="checkbox"/> CRC – Critical Care | <input type="checkbox"/> ORT – Orthopedics | <input type="checkbox"/> DOS – Dentistry/Oral Surgery | <input type="checkbox"/> OSS – Other Surgical Specialty | <input type="checkbox"/> DER – Dermatology | <input type="checkbox"/> OTH – Other Clinical Specialty | <input type="checkbox"/> ENT – Ear, Nose and Throat | <input type="checkbox"/> PAT – Pathology | <input type="checkbox"/> ERM – Emergency Medicine | <input type="checkbox"/> PED – Pediatrics | <input type="checkbox"/> FAP – Family Practice | <input type="checkbox"/> PLS – Plastic Surgery | <input type="checkbox"/> GAS – Gastroenterology | <input type="checkbox"/> PMR – Physical Medicine/Rehab | <input type="checkbox"/> GEN – General Surgery/Trauma | <input type="checkbox"/> PSC – Psychiatry | <input type="checkbox"/> IND – Infectious Diseases | <input type="checkbox"/> PUL – Pulmonology | <input type="checkbox"/> INM – Internal Medicine | <input type="checkbox"/> RAD – Radiology | <input type="checkbox"/> MSU – Other Medical Subspecialty | <input type="checkbox"/> URO – Urology | <input type="checkbox"/> NEP – Nephrology | <input type="checkbox"/> VAS – Vascular Surgery | <input type="checkbox"/> NEU – Neurology | |
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| <input type="checkbox"/> NEU – Neurology | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Performs direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment and/or monitoring): | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <small>Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)). Public reporting burden of this collection of information is estimated to average 20 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, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666). CDC 57.204 (Front), v6.6</small> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Custom Fields | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%; padding: 5px;">Label</th> <th style="width: 30%; padding: 5px; text-align: center;">/ /</th> </tr> </thead> <tbody> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> </tbody> </table> | Label | / / | | | | | | | | | | | | | | | <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%; padding: 5px;">Label</th> <th style="width: 30%; padding: 5px; text-align: center;">/ /</th> </tr> </thead> <tbody> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> <tr><td style="border-bottom: 1px solid black; height: 20px;"></td><td style="border-bottom: 1px solid black;"></td></tr> </tbody> </table> | Label | / / | | | | | | | | | | | | | | | | |
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