

**Appendix B – Individual Respondent Characteristics (Providers)**

**Diagnostic Safety Capacity Building – TeamSTEPPS®  
Resource**

Form Approved OMB No. xxxx-xxxx Exp. Date xx/xx/20
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Please complete the following information about yourself. This document is completed at the time of recruitment/interview/focus group

**Individual Respondent Characteristics Survey (Provider)**

Characteristic	Response Option*
<b>Participant Category</b>	<input type="checkbox"/> Provider <input type="checkbox"/> Staff <input type="checkbox"/> Administrator <input type="checkbox"/> Other: _____
<b>Sex</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Race</b>	Check all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____
<b>Ethnicity</b>	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
<b>Education Level</b>	<input type="checkbox"/> Elementary <input type="checkbox"/> High School Diploma <input type="checkbox"/> Some College <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor’s degree <input type="checkbox"/> Master’s degree <input type="checkbox"/> Professional Degree <input type="checkbox"/> Doctorate
<b>Age</b>	Age (years): _____
<b>Location</b>	City, State: _____
<b>Setting Type</b>	<input type="checkbox"/> Office-based practice <ul style="list-style-type: none"> <li><input type="radio"/> Primary Care</li> <li><input type="radio"/> Specialty Care</li> <li><input type="radio"/> FQHC</li> <li><input type="radio"/> Multispecialty</li> </ul> <input type="checkbox"/> Urgent Care Center <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____
*Each characteristic must include an option for did not respond/did not provide an answer	

This survey is authorized under 42 U.S.C. 299a. The confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average 60 minutes per response, the estimated time required to complete the survey. 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: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857.