

MDS: PHYSICIANS

Demographics

1. Birth date **Month** **Day** **Year**

2. Sex: ☐ Male ☐ Female

3. Race (1 or more categories may be selected)—Recommended as Optional

- ☐ White ☐ Black or African American
☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian/Other Pacific Islander ☐ Other (specify) _____

The workgroup acknowledges that this is a condensed list and state boards may choose to use more detailed response sets (e.g., HHS Data Standards for Race and US Census Bureau Race Categories).

4. Ethnicity

Are you Hispanic, Latino/a, or of Spanish origin?

(1 or more categories may be selected)—Recommended as Optional

- ☐ No ☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican ☐ Yes, Cuban
☐ Yes, Another Hispanic, Latino/a, or of Spanish origin (specify) _____

5. Do you speak a language other than English at home? (optional)

- ☐ Yes
☐ No

6. What is this language? (if you answered Yes to #5)

- ☐ Spanish
☐ Other Language (identify) _____

Education & Training

6. Medical Education

A. What is your medical degree?

- ☐ M.D. ☐ D.O. ☐ M.B.B.S.

B. What year did you complete your medical degree?

C. Where did you complete your medical degree?

- ☐ United States (specify state): _____
Medical School Name _____
☐ Foreign Country (specify): _____

7. Residency Training/Graduate Medical Education

A. First Specialty Training

- Location (State) _____
- Number of Years of Training _____
- Year Completed _____

B. Subspecialty Training

- Location (State) _____
- Number of Years of Training _____
- Year Completed _____

C. Additional Training

- Location (State) _____
- Number of Years of Training _____
- Year Completed _____

8. Training and Certification

	Completed Accredited Residency Program / Fellowship		Board Certified	
Principal Specialty	☐ Yes	☐ No	☐ Yes	☐ No
Secondary Specialty	☐ Yes	☐ No	☐ Yes	☐ No

Practice Characteristics

9. What is your employment status?

- ☐ Actively working in a position that requires a medical license
- ☐ Actively working in a field other than medicine
- ☐ Not currently working
- ☐ Retired

10. Are you currently providing direct clinical or patient care on a regular basis?

- ☐ Yes
- ☐ No

11. If no, how many years has it been since you provided clinical or patient care?

- ☐ Less than 2 years
- ☐ 2 to 5 years
- ☐ 5 to 10 years
- ☐ More than 10 years

12. Which of the following best describes the area(s) of practice in which you spend most of your professional time:

Area of Practice	Principal	Secondary	Completed Accredited Residency Program or Fellowship
Adolescent Medicine	☐	☐	☐
Anesthesiology	☐	☐	☐
Allergy and Immunology	☐	☐	☐
Cardiology	☐	☐	☐
Child Psychiatry	☐	☐	☐
Colon and Rectal Surgery	☐	☐	☐
Critical Care Medicine	☐	☐	☐
Dermatology	☐	☐	☐
Endocrinology	☐	☐	☐
Emergency Medicine	☐	☐	☐
Family Medicine/General Practice	☐	☐	☐
Gastroenterology	☐	☐	☐
Geriatric Medicine	☐	☐	☐
Gynecology Only	☐	☐	☐

Hematology & Oncology	☐	☐	☐
Infectious Diseases	☐	☐	☐
Internal Medicine (General)	☐	☐	☐
Nephrology	☐	☐	☐
Neurological Surgery	☐	☐	☐
Neurology	☐	☐	☐
Obstetrics and Gynecology	☐	☐	☐
Occupational Medicine	☐	☐	☐
Ophthalmology	☐	☐	☐
Orthopedic Surgery	☐	☐	☐
Other Surgical Specialties	☐	☐	☐
Otolaryngology	☐	☐	☐
Pathology	☐	☐	☐
Pediatrics (General)	☐	☐	☐
Pediatrics Subspecialties	☐	☐	☐
Physical Med. & Rehab.	☐	☐	☐
Plastic Surgery	☐	☐	☐
Preventive Medicine/Public Health	☐	☐	☐
Psychiatry	☐	☐	☐
Pulmonology	☐	☐	☐
Radiation Oncology	☐	☐	☐
Radiology	☐	☐	☐
Rheumatology	☐	☐	☐
Surgery (General)	☐	☐	☐
Thoracic Surgery	☐	☐	☐
Urology	☐	☐	☐
Vascular Surgery	☐	☐	☐
Other Specialties	☐	☐	☐

13. Which of the following categories best describes your primary and secondary practice or work setting(s) where you work the most hours each week?

Practice Setting	Principal	Secondary
Office/Clinic—Solo Practice	☐	☐
Office/Clinic—Partnership	☐	☐
Office/Clinic—Single Specialty Group	☐	☐
Office/Clinic—Multi Specialty Group	☐	☐
Hospital—Inpatient	☐	☐
Hospital—Outpatient	☐	☐
Hospital—Emergency Department	☐	☐

Hospital—Ambulatory Care Center	☐	☐
Federal Government Hospital	☐	☐
Research Laboratory	☐	☐
Medical School	☐	☐
Nursing Home or Extended Care Facility	☐	☐
Home Health Setting	☐	☐
Hospice Care	☐	☐
Federal/State/Community Health Center(s)	☐	☐
Local Health Department	☐	☐
Telemedicine	☐	☐
Volunteer in a Free Clinic	☐	☐
Other (specify):	☐	☐

14. How many weeks did you work in medical related positions in the past 12 months? __

15. For all medical related positions held in (insert state name), indicate the average number of hours per week spent on each major activity:

Clinical or patient care	_____ hours/week
Research	_____ hours/week
Teaching/Education	_____ hours/week
Administration	_____ hours/week
Volunteering (medical related only)	_____ hours/week
Other (specify): _____	_____ hours/week

Another approach to obtaining this information would be to ask licensees: (1) number of weeks worked in the past 12 months, (2) average number of hours worked per week, and (3) the percentage of time per week spent on each major activity (e.g., clinical or patient care, research etc.).

16. What is the location of the site(s) where you spend most of your time providing direct clinical or patient care? Please enter the complete address for up to three locations and your direct patient care hours per week at each site.

(The workgroup strongly recommends collecting full addresses if all possible, but zip codes only would be acceptable for a minimal data set.)

Principal Location Address

Number _____	Street _____
City/Town _____	State _____ Zip Code: □□□□□

Direct patient care hours per week at site: _____

Second Location Address

Number Street

City/Town State Zip Code: □□□□□

Direct patient care hours per week at site: _____

Third Location Address

Number Street

City/Town State Zip Code: □□□□□

Direct patient care hours per week at site: _____