30203

VERMONT DEPARTMENT OF HEALTH
Advanced Practice Nursing Survey 2002

This survey is designed to assess the distribution of advanced practice nursing resources throughout the state and assist in recruitment and retention efforts. Please answer all questions completely. If you have any questions, please contact the Department of Health at (802) 863-7300 or (800) 869-2871. Thank you for your cooperation.

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(Please print legibly using a dark blue or black pen and uppercase letters; fill in small check boxes entirely)

Vermont License Number: 1 0 1 - 0 0 _ _ _ _ _

Gender: ☐ Male ☐ Female

Date of Birth: Month ___ / Day ___ / Year ___

First Name

Middle Name

Last Name

Daytime Phone Number: ___ - ___ - ____

(Please fill in check boxes completely using a blue or black pen)

1. Choose all of the activities that describe your practice as an Advanced Practice Nurse: (Please fill in all the boxes below that apply)

☐ Provide patient care in Advanced Practice Nursing in Vermont
☐ Provide patient care in Advanced Practice Nursing outside Vermont .....
☐ Provide patient care in another nursing role in Vermont .....
☐ Retired from advanced practice nursing .....

IF YOU DO NOT PROVIDE PATIENT CARE IN ADVANCED PRACTICE NURSING IN VERMONT, PLEASE STOP HERE AND RETURN SURVEY

2. What is the highest level of nursing education that you have completed? (Please fill in one box)

☐ Diploma
☐ ADN (Associate Degree in Nursing)
☐ BSN (Bachelor of Science in Nursing)
☐ MSN (Master of Science in Nursing)
☐ Doctoral Degree in Nursing
☐ Other:_____

3. Do you have another (non-nursing) degree(s)? (Please fill in all that apply)

☐ Master of Public Health
☐ Master of Science (non-nursing)
☐ Master of Arts or Science
☐ Bachelor of Arts or Science
☐ Doctoral Degree (non-nursing)
☐ Other:_____

4. What is your Advanced Practice Nursing preparation? (Please fill in one box)

☐ Certificate
☐ MSN
☐ Other:_____

5. What type of Advanced Practice Nurse are you? (Please fill in all that apply)

☐ Nurse Practitioner (NP)
☐ Certified Nurse Midwife (CNM)
☐ Clinical Nurse Specialist (CNS)
☐ Certified RN Anesthetist (CRNA)

6. In what areas do you hold credentials as an Advanced Practice Nurse? (Please fill in all that apply)

Primary Care

☐ Adult
☐ Family
☐ Gerontology
☐ Midwifery
☐ Ob/Gyn (Women's Health)
☐ Pediatrics
☐ Other:_____

Specialty Care

☐ Acute or Emergency Care
☐ Anesthesiology
☐ Medical/Surgical
☐ Psych/Mental Health
☐ School
☐ Other:_____

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Vermont License Number

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(Please re-enter your license number for scanning purposes)

7. What month/year did you start working as an advanced practice nurse? ☐☐ - ☐☐ (Month / Year)

8. What month/year did you start working as an advanced practice nurse in Vermont? ☐☐ - ☐☐ (Month / Year)

9. Do you plan to retire or reduce your hours in the next 12 months? ☐ Yes ☐ No

10. Do you have hospital admitting privileges (under your own name) in Vermont? ☐ Yes ☐ No

11. Do you have prescriptive authority in Vermont? ☐ Yes ☐ No

12. Do you work on-call hours evening and/or weekends? ☐ Yes ☐ No

For each Vermont setting where you provide patient care, enter the name of the town, one practice setting, up to two specialties, the weeks per year and the average hours per working week you provide DIRECT PATIENT CARE within each specialty. Include both ambulatory care and hospital care of patients who originate from this site. Exclude on-call hours and hours spent reviewing patient management with a physician(s). Please answer the questions concerning your plans to continue at this site, locum tenens, on-call hours and new patients.

SITE ONE - (Enter Vermont town name, not a mailing address)

Please fill in one practice setting box:

- ☐ Solo APRN Practice
- ☐ APRN Practice Group
- ☐ Physician/APRN Practice
- ☐ Community Health Center/Clinic
- ☐ School or College Health Center
- ☐ Business or Work Site
- ☐ Extended Care/Nursing Home
- ☐ Home Health Agency
- ☐ Hospital-based practice (ER, inpatient, outpatient, etc)

Please enter one or two specialties from the list on the right, the **weeks per year** and the **average hours per work week** you spend providing DIRECT PATIENT CARE within each specialty. (**Exclude** hours spent reviewing patient management with a physician(s); **exclude** on-call hours.)

Specialty 1 ☐☐ **Specialty 2** ☐☐

(We consider 48 weeks per year to be full time.)

Weeks 1 ☐☐ **Weeks 2** ☐☐

Hours/week ☐☐ **Hours/week** ☐☐

Primary Care Codes
01=Adult
02=Family
03=Gerontology
04=Midwifery
05=Ob/Gyn (Women's Health)
06=Pediatric
07=Other_____

Specialty Care Codes
08=Acute or Emergency
09=Anesthesiology
10=Medical/Surgical
11=Psych/Mental Health
12=School
13=Other_____

Please fill in the 'Yes' or 'No' box for all six questions:

- ☐ Yes ☐ No I will accept new patients at this site
- ☐ Yes ☐ No I participate in Medicaid at this site
- ☐ Yes ☐ No I will accept new Medicaid patients at this site
- ☐ Yes ☐ No I participate in Medicare at this site
- ☐ Yes ☐ No I will accept new Medicare patients at this site
- ☐ Yes ☐ No I work as a locum tenens at this site

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Vermont License Number

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(Please re-enter your license number for scanning purposes)

SITE TWO - (Enter Vermont town name, not a mailing address)

Please fill in one practice setting box:

- ☐ Solo APRN Practice
- ☐ APRN Practice Group
- ☐ Physician/APRN Practice
- ☐ Community Health Center/Clinic
- ☐ School or College Health Center
- ☐ Business or Work Site
- ☐ Extended Care/Nursing Home
- ☐ Home Health Agency
- ☐ Hospital-based practice (ER, inpatient, outpatient, etc)

Please enter one or two specialties from the list on the right, **weeks per year** and the **average hours per work week** you spend providing DIRECT PATIENT CARE within each specialty. (**Exclude** hours spent reviewing patient management with a physician(s); **exclude** on-call hours.)

Specialty 1 ☐☐ **Specialty 2** ☐☐

(We consider 48 weeks per year to be full time.)

Weeks 1 ☐☐ **Weeks 2** ☐☐

Hours/week ☐☐ **Hours/week** ☐☐

Primary Care Codes
01=Adult
02=Family
03=Gerontology
04=Midwifery
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Specialty Care Codes
08=Acute or Emergency
09=Anesthesiology
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12=School
13=Other_____

Please fill in the 'Yes' or 'No' box for all six questions:

- ☐ Yes ☐ No I will accept new patients at this site
- ☐ Yes ☐ No I participate in Medicare at this site
- ☐ Yes ☐ No I participate in Medicaid at this site
- ☐ Yes ☐ No I will accept new Medicare patients at this site
- ☐ Yes ☐ No I will accept new Medicaid patients at this site
- ☐ Yes ☐ No I work as a locum tenens at this site

SITE THREE - (Enter Vermont town name, not a mailing address)

Please fill in one practice setting box:

- ☐ Solo APRN Practice
- ☐ APRN Practice Group
- ☐ Physician/APRN Practice
- ☐ Community Health Center/Clinic
- ☐ School or College Health Center
- ☐ Business or Work Site
- ☐ Extended Care/Nursing Home
- ☐ Home Health Agency
- ☐ Hospital-based practice (ER, inpatient, outpatient, etc)

Please enter one or two specialties from the list on the right, **weeks per year** and the **average hours per work week** you spend providing DIRECT PATIENT CARE within each specialty. (**Exclude** hours spent reviewing patient management with a physician(s); **exclude** on-call hours.)

Specialty 1 ☐☐ **Specialty 2** ☐☐

(We consider 48 weeks per year to be full time.)

Weeks 1 ☐☐ **Weeks 2** ☐☐

Hours/week ☐☐ **Hours/week** ☐☐

Primary Care Codes
01=Adult
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Specialty Care Codes
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12=School
13=Other_____

Please fill in the 'Yes' or 'No' box for all six questions below:

- ☐ Yes ☐ No I will accept new patients at this site
- ☐ Yes ☐ No I participate in Medicare at this site
- ☐ Yes ☐ No I participate in Medicaid at this site
- ☐ Yes ☐ No I will accept new Medicare patients at this site
- ☐ Yes ☐ No I will accept new Medicaid patients at this site
- ☐ Yes ☐ No I work as a locum tenens at this site

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