2017 Dental Hygienist Re-Licensure Survey Instrument

1. Sex
   DROP DOWN
   a. Male
   b. Female

2. What is your race? Mark one or more boxes.
   MULTI CHECK BOX
   a. White
   b. American Indian or Alaska Native
   c. Native Hawaiian/Pacific Islander
   d. Black or African American
   e. Asian
   f. Some Other Race

3. Are you of Hispanic or Latino origin?
   RADIO BUTTONS
   a. Yes
   b. No

4. What type of dental hygiene degree/credential qualified you for your first U.S. dental hygiene license?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. Vocational/Practical certificate – dental hygiene
   b. Diploma – dental hygiene
   c. Associate degree – dental hygiene
   d. Baccalaureate degree – dental hygiene
   e. Master’s degree – dental hygiene
   f. Doctoral degree – dental hygiene

5. Where did you complete the dental hygiene degree/credential that qualified you for your first U.S. dental hygiene license?
   DROP DOWN LIST
   a. Indiana
   b. Michigan
   c. Illinois
   d. Kentucky
   e. Ohio
   f. Another State (not listed)
   g. Another Country (not U.S.)
6. What is your highest level of education?
   DROP-DOWN LIST OR RADIO BUTTONS
   Vocational/Practical certificate – dental hygiene
   Diploma – dental hygiene
   Associate degree – dental hygiene
   Associate degree – other field
   Baccalaureate degree – dental hygiene
   Baccalaureate degree – other field
   Master’s degree – dental hygiene
   Master’s degree – other field
   Doctoral degree – dental hygiene
   Doctoral degree – other field

7. What is your employment status?
   RADIO BUTTONS
   a. Actively working in a position that requires a dental hygiene license
   b. Actively working in a dental hygiene related field that does not require a dental hygiene license
   c. Actively working in a field that does not require a dental hygiene license
   d. Not currently working, disabled
   e. Not currently working, seeking work in a position that requires a dental hygiene license
   f. Not currently working, seeking work in a position that does not require a dental hygiene license
   g. Student
   h. Leave of absence or Sabbatical
   i. Retired

8. How many months did you work in dental hygiene in the past year?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. I did not work in dental hygiene in the past year.
   b. Less than 3 months.
   c. More than 3 months but less than 6 months
   d. More than 6 months but less than 9 months
   e. More than 9 months, up to 12 months

9. Please indicate in which field you spend the majority of your time.
   DROP-DOWN LIST OR RADIO BUTTONS
   a. Direct Patient Care – dental hygiene
   b. Direct Patient Care – other
   c. Research – dental hygiene
   d. Research – other
   e. Education – dental hygiene
   f. Education – other
   g. Administration – dental hygiene
   h. Administration – other
   i. Other
10. Are you currently working as many hours as you would like in dental hygiene?  
   DROP-DOWN LIST OR RADIO BUTTONS  
   a. Yes  
   b. No  

11. If NO, how many more hours a week would you like to be working in dental hygiene?  
   DROP-DOWN LIST OR RADIO BUTTONS  
   a. Less than 8 additional hours per week  
   b. Between 9 and 16 additional hours per week  
   c. Between 17 and 24 additional hours per week  
   d. Between 25 and 32 additional hours per week  
   e. Between 33 and 40 additional hours per week  
   f. More than 40 additional hours per week  

12. What are your employment plans for the next 12 months?  
   DROP-DOWN LIST OR RADIO BUTTONS  
   a. Increase hours in patient care  
   b. Decrease hours in patient care  
   c. Seek employment in a field outside of patient care  
   d. Leave direct patient care to complete further training  
   e. Leave direct patient care for family reasons/commitments  
   f. Leave direct patient care due to physical demands  
   g. Leave direct patient care due to stress/burnout  
   h. Retire  
   i. Continue as you are  
   j. Unknown  

13. Is your primary practice located in the state of Indiana *(the position in which you spend the majority of your time)*?  
   RADIO BUTTON  
   a. Yes  
   b. No  

14. If located in Indiana, what is the county of your primary practice location?  
   ________________ (free text)  

15. If located in Indiana, what is the zip code of your primary practice location?  
   ________________ (free text)
16. How many hours do you spend in direct care per week at your principal practice site?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. 0 hours per week
   b. 1 – 4 hours per week
   c. 5 – 8 hours per week
   d. 9 – 12 hours per week
   e. 13 – 16 hours per week
   f. 17 – 20 hours per week
   g. 21 – 24 hours per week
   h. 25 – 28 hours per week
   i. 29 – 32 hours per week
   j. 33 – 36 hours per week
   k. 37 – 40 hours per week
   l. 41 or more hours per week

17. Which best describes the type of setting that most closely corresponds to your principal direct patient care practice site:
   DROP-DOWN LIST OR RADIO BUTTONS
   a. Dental office practice - Solo practice
   b. Dental office practice - Partnership
   c. Dental office practice - Group practice
   d. Specialty Practice
   e. Hospital/Clinic
   f. Federal Government Hospital/Clinic (includes Military)
   g. Health Center (CHC/FQHC/FQHC look-alike)
   h. Long Term Care/Nursing home/Extended Care Facility (non-hospital)
   i. Home health setting
   j. Local health department
   k. Other Public Health/Community Health Setting
   l. School health service
   m. Mobile Unit Dentistry
   n. Correctional Facility
   o. Indian Health Service
   p. Headstart (including early Headstart)
   q. Staffing organization
   r. Other setting

18. If you hold more than one position in dental hygiene, is your secondary practice located in the state of Indiana?
   RADIO BUTTON
   c. Yes
   d. No

19. If located in Indiana, what is the county of your secondary practice location?
    ________________________________ (free text)
20. If located in Indiana, what is the zip code of your secondary practice location?

_____________________________ (free text)

21. How many hours do you spend in direct care per week at your secondary practice site? If you do not have a secondary practice site, please skip this question.

DROP-DOWN LIST OR RADIO BUTTONS
a. 0 hours per week
b. 1 – 4 hours per week
c. 5 – 8 hours per week
d. 9 – 12 hours per week
e. 13 – 16 hours per week
f. 17 – 20 hours per week
g. 21 – 24 hours per week
h. 25 – 28 hours per week
i. 29 – 32 hours per week
j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week

22. Which best describes the type of setting that most closely corresponds to your secondary direct patient care practice site? (If you do not have a secondary practice site, please skip this question.)

DROP-DOWN LIST OR RADIO BUTTONS
a. Dental office practice - Solo practice
b. Dental office practice - Partnership
c. Dental office practice - Group practice
d. Specialty Practice
e. Hospital/Clinic
f. Federal Government Hospital/Clinic (includes Military)
g. Health Center (CHC/FQHC/FQHC look-alike)
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