



INDIANA UNIVERSITY

SCHOOL OF MEDICINE

Bowen Center for Health Workforce Research and Policy

2016 Respiratory Care Practitioner Re-Licensure Survey Instrument

1. Sex
Dropdown List
 - a. Male
 - b. Female

2. Ethnicity: Are you Hispanic or Latino?
Yes/No Dropdown
 - a. Yes
 - b. No

3. Race (Check all that apply.)
Multi Checkbox
 - a. American Indian or Alaska Native
 - b. Black or African American
 - c. White
 - d. Asian
 - e. Native Hawaiian or Other Pacific Islander
 - f. Other

4. Where did you complete the degree/credential that qualified you for your first U.S. respiratory care practitioner license?
Dropdown List
 - a. Indiana
 - b. Michigan
 - c. Illinois
 - d. Kentucky
 - e. Ohio
 - f. Another State (not listed)
 - g. Another Country (not U.S.)

5. What type of degree/credential qualified you for your first U.S. respiratory care practitioner license?
Dropdown List
 - a. Vocational/Practical Certificate
 - b. Diploma
 - c. Associate Degree
 - d. Bachelor's Degree
 - e. Master's Degree
 - f. Doctoral Degree
 - g. Military Training Certification
 - h. Other

6. What year did you complete the respiratory care education that first qualified you for your U.S. respiratory care practitioner license? Please indicate using the four digit year.

TEXT BOX

7. What is your highest earned degree/credential?

Dropdown List

- a. Vocational/Practical Certificate
- b. Diploma
- c. Associate Degree
- d. Bachelor's Degree
- e. Master's Degree
- f. Doctoral Degree
- g. Military Training Certification
- h. Other

8. Please select which credentials you have earned.

Multi Checkbox

- a. CRT (Certified Respiratory Therapist)
- b. RRT (Registered Respiratory Therapist)
- c. Neonatal/Pediatric Specialist
- d. CPFT (Certified Pulmonary Function Technologist)
- e. RPFT (Registered Pulmonary Function Technologist)
- f. R.EEG.T (Registered EEG Technologist)
- g. R.EP.T (Registered Electrophysiology Technologist)
- h. RPSGT (Registered Polysomnographic Technologist)
- i. CHT (Certified Hyperbaric Technologist)
- j. AE-C (Certified Asthma Educator)
- k. LVN (Licensed Vocational Nurse)
- l. RN (Registered Nurse)
- m. EMT (Emergency Medical Technician)
- n. Paramedic
- o. CCT (Certified Cardiographic Technician)
- p. Registered Cardiovascular Invasive Specialist
- q. CCM (Certified Case Manager)
- r. BCLS (Basic Cardiac Life Support)
- s. ACLS (Advanced Cardiac Life Support)
- t. PALS or APLS (Advanced Pediatric Life Support)
- u. NRP (Neonatal Resuscitation Protocol)
- v. BTLS (Basic Trauma Life Support)
- w. S.T.A.B.L.E.
- x. Other

9. What is your employment status?

Dropdown List

- a. Actively working in the field of respiratory care
- b. Actively working in a field other than respiratory care
- c. Unemployed but seeking work in respiratory care
- d. Unemployed, not seeking work in respiratory care
- e. Retired

10. How many weeks did you work in respiratory care in the past year? Please approximate and enter a number 1 through 52 (no decimals).

Text box

11. What are your employment plans for the next 12 months?

Dropdown List

- a. Increase hours in the field of respiratory care
- b. Decrease hours in the field of respiratory care
- c. Leave employment in the field of respiratory care and seek work elsewhere
- d. Retire
- e. No planned change

12. Please indicate in which major activity you spend the majority of your time:

Dropdown List

- a. Administration/management
- b. Direct patient care (includes hands-on care, documentation, and patient education)
- c. Indirect patient care (includes planning, consulting, assigning and teaching staff, evaluating care)
- d. Education of student RCPs
- e. Other

13. In how many locations do you provide respiratory care services?

Dropdown List

- a. 0
- b. 1
- c. 2
- d. 3
- e. 4 or more

14. Where is your primary practice (the location you spend the majority of your time as a respiratory care practitioner) located?

Dropdown List

- a. Indiana
- b. Michigan
- c. Illinois
- d. Kentucky
- e. Ohio
- f. Another State (not listed)
- g. Another Country (not U.S.)

15. If your primary practice is located in Indiana, please provide the county in which it is located.

TEXT-BOX

16. Please identify the type of setting that most closely corresponds to your primary practice location.

Dropdown List

- a. Acute Care Hospital
- b. Durable Medical Equipment/Home Care
- c. Long-term Acute Care/Rehabilitation Hospital/Sub-Acute Care
- d. Skilled Nursing Facility
- e. Accredited Education Program
- f. Manufacturer/Distributor
- g. Outpatient Facility/Physician's Office
- h. Other

17. What is your primary specialty area of practice at your primary practice location?

Dropdown List

- a. Adult Critical Care
- b. Neonatal Critical Care
- c. Pediatric Critical Care
- d. Case Management
- e. Chronic Disease Management
- f. Education
- g. ECMO
- h. Geriatrics
- i. Home Care
- j. Invasive Cardiology
- k. Hyperbaric Medicine
- l. Long-term Care
- m. Polysomnography
- n. Pulmonary Diagnostics
- o. Pulmonary Rehabilitation
- p. Rehabilitation
- q. Transport
- r. Trauma
- s. Other

18. How many hours do you spend in direct care per week at this location?

Dropdown List

- 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