HD1112F

pennsylvania DEPARTMENT OF HEALTH

Commonwealth of Pennsylvania
Department of Health
2016-2017 Survey of Registered Nurses

License #: RN _____

* ***Required to avoid duplication***

* ***Anonymous & aggregate reporting only***

DO NOT MAIL THIS SURVEY IF YOU HAVE ALREADY SUBMITTED YOUR RENEWAL SURVEY ONLINE.

The Department of Health, with the support of the Department of State, requests that you complete this survey to assist in the important work of understanding and projecting the nursing workforce. Strict controls are placed upon information when shared for the production of statistical reports and analysis. This information, when released to the public, will be in aggregate form only. To view past workforce reports visit www.health.pa.gov. Thank you for your cooperation!

1. Year of Birth ☐☐☐☐ 2. Sex ☐ Male ☐ Female 3. Hispanic or Latino Origin ☐ Yes ☐ No

4. Race (*check one*) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Two or more races
☐ Other _____

5. State of Residence (*enter two letter postal code*) ☐☐ 5a. County of Residence (*PA only – see codes on page 4*) ☐☐

6. What type of nursing degree/credential qualified you for your first U.S. nursing license?
☐ Vocational/Practical certificate ☐ Diploma ☐ Associate ☐ Bachelor's ☐ Master's ☐ Doctoral

6a. In what year did you obtain this first U.S. nursing license? ☐☐☐☐

7. In what country were you initially licensed as an RN or LPN? ☐ United States ☐ Other _____

8. In what year did you obtain your first U.S. RN license? ☐☐☐☐

8a. In what state was this first U.S. RN license issued? *(two letter postal code)* ☐☐

9. What is your highest level of nursing education completed? (*check one*)
☐ Diploma – nursing ☐ Associate – nursing ☐ Bachelor's – nursing ☐ Master's – nursing
☐ Doctoral – nursing (PhD) ☐ Doctoral – nursing (DNP) ☐ Doctoral – nursing (other)

10. If applicable, what is your highest level of non-nursing education completed? (*check one*)
☐ Associate – non-nursing ☐ Bachelor's – non-nursing ☐ Master's – non-nursing ☐ Doctoral – non-nursing
☐ Not applicable

11. Have you completed an advanced nursing practice education program? ☐ Yes ☐ No >> ***if 'No', skip to question 12***

11a. Which of the following have you completed? (*check all that apply*)
☐ CNM=Nurse Midwife ☐ CNS=Clinical Nurse Specialist ☐ CRNA=Nurse Anesthetist ☐ CRNP=Nurse Practitioner

	CNM	**CNS**	**CRNA**	**CRNP**
11b. Year you completed advanced practice education	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
11c. State of your advanced practice program (*2 letter postal code*)	☐☐	☐☐	☐☐	☐☐
11d. Do you hold a national certification in this role? *(check if yes)*	☐	☐	☐	☐
11e. Do you hold a state certification in this role? *(check if yes)*	☐	☐	**N/A**	☐
11f. Are you currently practicing in any of these roles? *(check if yes)*	☐	☐	☐	☐
11g. Do you practice with an on-site physician? *(check if yes)*	☐	☐	☐	☐
11h. Do you practice in a primary care setting? *(check if yes)*	☐	☐	☐	☐
11i. Have you experienced limits/barriers to your practice? (*check if yes*)	☐	☐	☐	☐

11j. If you checked yes to 11i, please indicate the type(s) of limitation(s)/barrier(s) you encounter: *(check all that apply)*
☐ Facility ByLaws ☐ Finding Collaborating Physicians ☐ Insurance Reimbursement for Services
☐ Regulations/Scope of Practice Laws ☐ Insurer Credentialing ☐ Other_____

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12. Are you currently in the process of continuing your nursing education? ☐ Yes ☐ No >> ***if 'No', skip to question 13***

12a. What type of nursing degree are you primarily pursuing?
☐ Associate ☐ Bachelor's ☐ Master's ☐ Post-masters ☐ Doctoral ☐ Other

12b. Indicate if you are currently pursuing any of the following advanced nursing education programs.
☐ Nurse Midwife ☐ Clinical Nurse Specialist ☐ Nurse Anesthetist ☐ Nurse Practitioner ☐ None

12c. What is your anticipated graduation date?
☐ 0-2 years from today ☐ 3-4 years from today ☐ 5-6 years from today ☐ More than 6 years from today

13. What is your employment status? (*select the **one** best fitting category*)
- ☐ Employed full-time in nursing or a position that requires a nursing license
- ☐ Employed part-time in nursing or a position that requires a nursing license
- ☐ Employed per diem in nursing or a position that requires a nursing license
- ☐ Employed full-time in a field other than nursing
- ☐ Employed part-time in a field other than nursing
- ☐ Employed per diem in a field other than nursing
- ☐ Working as a volunteer in a nursing position
- ☐ Unemployed, seeking work as a nurse
- ☐ Unemployed, not seeking work as a nurse
- ☐ Retired

>> If the answer to question 13 is 'working as a volunteer' or 'retired' or 'employed in a field other than nursing', you have completed this survey. Thank you very much!!

>> If the answer to question 13 is 'employed in nursing' (either full-time, part-time or per diem), skip to question 15

14. Please select the best reason for your being unemployed
- ☐ Difficulty in finding a nursing position
- ☐ I am currently disabled
- ☐ I am currently enrolled either part-time or full-time as a student
- ☐ Inadequate salary
- ☐ Taking care of home and family
- ☐ Other

>>If the answer to question 13 is 'unemployed', you have now completed the survey. Thank you very much!!

15. In what **state** is your primary job located? *(two letter postal code)* ☐☐

15a. In what **county** is your primary job located? (*PA only – see codes on page 4*) ☐☐

16. Please check the type of setting that most closely corresponds to your primary nursing practice position. (***check one***)
- ☐ Academic Setting
- ☐ Ambulatory Care Setting
- ☐ Community Health
- ☐ Correctional Facility
- ☐ Home Health
- ☐ Hospital
- ☐ Insurance Claims/Benefits
- ☐ Nursing Home/Extended Care/Assisted Living Facility
- ☐ Occupational Health
- ☐ Policy/Planning/Regulatory/Licensing Agency
- ☐ Public Health
- ☐ School Health Service
- ☐ Other

17. Please check the type of job that most closely corresponds to your primary nursing practice position. (***check one***)
Note: For purposes of this survey, direct patient care includes the amount of time a nurse spends directly with patients in a medical setting; including time spent on patient record keeping and patient specific office work. This would also include 'on call' hours if the nurse is required to remain in a medical facility.

☐ Direct Patient Care

Indirect Patient Care:
- ☐ Administration/Management
- ☐ Infection Prevention/Control
- ☐ Nursing School Faculty/Administration
- ☐ Researcher/Consultant
- ☐ Case Management
- ☐ Informatics/Health Information Technology
- ☐ Patient Staff Education
- ☐ Other

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18. Please check the employment specialty that most closely corresponds to your primary nursing practice position. (***check one***)

- ☐ Acute Care/Critical Care
- ☐ Administrative
- ☐ Adult Health/Family Health
- ☐ Anesthesia
- ☐ Case Management
- ☐ Community
- ☐ Education
- ☐ Emergency Care
- ☐ Geriatric/Gerontology
- ☐ Home Health
- ☐ Hospice
- ☐ Maternal-Child Health
- ☐ Medical Surgical
- ☐ Occupational Health
- ☐ Oncology
- ☐ Palliative Care
- ☐ Pediatrics/Neonatal
- ☐ Public Health
- ☐ Psychiatric/Mental Health/Substance Abuse
- ☐ Quality Assurance
- ☐ Rehabilitation
- ☐ School Health
- ☐ Trauma
- ☐ Women's Health
- ☐ Other
- ☐ No Specialty

19. In how many positions are you currently employed as a nurse? ☐ 1 ☐ 2 ☐ 3 or more

>> If the answer to question 19 is '1', skip to question 22

20. Please check the type of setting that most closely corresponds to your secondary nursing practice position. (***check one***)

- ☐ Academic Setting
- ☐ Ambulatory Care Setting
- ☐ Community Health
- ☐ Correctional Facility
- ☐ Home Health
- ☐ Hospital
- ☐ Insurance Claims/Benefits
- ☐ Nursing Home/Extended Care/Assisted Living Facility
- ☐ Occupational Health
- ☐ Policy/Planning/Regulatory/Licensing Agency
- ☐ Public Health
- ☐ School Health Service
- ☐ Other

21. Please check the employment specialty that most closely corresponds to your secondary nursing practice position. (***check one***)

- ☐ Acute Care/Critical Care
- ☐ Administrative
- ☐ Adult Health/Family Health
- ☐ Anesthesia
- ☐ Case Management
- ☐ Community
- ☐ Education
- ☐ Emergency Care
- ☐ Geriatric/Gerontology
- ☐ Home Health
- ☐ Hospice
- ☐ Maternal-Child Health
- ☐ Medical Surgical
- ☐ Occupational Health
- ☐ Oncology
- ☐ Palliative Care
- ☐ Pediatrics/Neonatal
- ☐ Public Health
- ☐ Psychiatric/Mental Health/Substance Abuse
- ☐ Quality Assurance
- ☐ Rehabilitation
- ☐ School Health
- ☐ Trauma
- ☐ Women's Health
- ☐ Other
- ☐ No Specialty

22. In a typical week, how many hours do you work in all of your nursing positions? ☐☐

23. In the past six months, did you personally provide language interpretive services to patients? (languages other than English)
☐ Yes ☐ No >>***If 'No', skip to question 24***

23a. In which language(s) did you personally provide language interpretive services to patients? *(check all that apply)*

- ☐ Arabic
- ☐ Chinese
- ☐ French
- ☐ German
- ☐ Hindi
- ☐ Italian
- ☐ PA Dutch
- ☐ Polish
- ☐ Russian
- ☐ Sign Language
- ☐ Spanish
- ☐ Urdu
- ☐ Vietnamese
- ☐ Other_____

24. In the past year, have you been impacted by workplace violence? ☐ Yes ☐ No

25. Please indicate your level of satisfaction with the following factors in your primary nursing job (*check one for each job factor)*

Salary	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
Benefits	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
Career development opportunity	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
Staffing levels	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
Efficiency of workplace processes	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
RN participation in decisions	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
RNs valued by administration	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
Supervisory relationship	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
Workplace emphasis on quality of care	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
Workplace emphasis on patient safety	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A
Workplace emphasis on staff safety	☐Very dissatisfied	☐Dissatisfied	☐ Satisfied	☐ Very Satisfied	☐ N/A

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26. How satisfied are you with your primary nursing job?
☐ Very dissatisfied ☐ Dissatisfied ☐ Satisfied ☐ Very Satisfied

27. How satisfied are you with nursing as a career?
☐ Very dissatisfied ☐ Dissatisfied ☐ Satisfied ☐ Very Satisfied

28. In your primary job, do you use computer systems to access patient health information (medical records, orders, etc.)?
☐ Yes ☐ No >>***If 'No', skip to question 31***

29. In your primary job, do you use computer systems (does not include faxing) to exchange patient health information (send or receive) with other health care providers/facilities?
☐ Yes ☐ No ☐ Not Sure

30. Please identify where you learned to use computer systems in your role as a nurse **(***check all that apply***)**.
☐ Nursing Education Program ☐ On-the-job Training ☐ Continuing Education

31. In your primary job in the past year, have you been asked by a patient about security or privacy of health information?
☐ Yes ☐ No ☐ Not applicable

31a. If you checked yes to question 31, did you have adequate information or resources to provide the answer?
☐ Yes ☐ No ☐ Not applicable

32. How much longer do you intend to remain employed in nursing?
☐ Less than 3 years ☐ 3 to less than 6 years ☐ 6 to less than 11 years ☐ 11 to less than 16 years ☐ 16+ years

33. If you plan to leave nursing in less than 6 years, indicate your primary reason below. **(***check one***)**
☐ Change Careers ☐ Financial Reasons ☐ Retirement ☐ Stress/Burnout
☐ Family Reasons ☐ Physical Demands ☐ Return to School ☐ Other

Thank you!

If you are interested in learning more about emergency disaster response effort volunteer opportunities in Pennsylvania, please access www.serv.pa.gov for more information.

Pennsylvania County Codes

01=Adams	11=Cambria	21=Cumberland	31=Huntingdon	41=Lycoming	51=Philadelphia	61=Venango
02=Allegheny	12=Cameron	22=Dauphin	32=Indiana	42=McKean	52=Pike	62=Warren
03=Armstrong	13=Carbon	23=Delaware	33=Jefferson	43=Mercer	53=Potter	63=Washington
04=Beaver	14=Centre	24=Elk	34=Juniata	44=Mifflin	54=Schuylkill	64=Wayne
05=Bedford	15=Chester	25=Erie	35=Lackawanna	45=Monroe	55=Snyder	65=Westmoreland
06=Berks	16=Clarion	26=Fayette	36=Lancaster	46=Montgomery	56=Somerset	66=Wyoming
07=Blair	17=Clearfield	27=Forest	37=Lawrence	47=Montour	57=Sullivan	67=York
08=Bradford	18=Clinton	28=Franklin	38=Lebanon	48=Northampton	58=Susquehanna	00=Not in PA
09=Bucks	19=Columbia	29=Fulton	39=Lehigh	49=Northumberland	59=Tioga	
10=Butler	20=Crawford	30=Greene	40=Luzerne	50=Perry	60=Union	

Pennsylvania State Board of Nursing
RENEWAL APPLICATION – REGISTERED NURSE
Expiration Date: 10/31/2016

_____
Full Name as it Appears on License (PRINT)

_____
Street Address as it Appears on License (PRINT)

_____
City **State** **Zip Code**

RETURN TO:
State Board of Nursing
PO Box 8412
Harrisburg, PA 17105-8412

_____
RN License Number

LICENSES CANNOT BE FORWARDED BY THE POSTAL SERVICE.	WARNING: Practicing on an expired license may result in disciplinary actions and additional monetary penalties.
FEE – Payable to "COMMONWEALTH OF PENNSYLVANIA" Write your license number on your payment.	**$65.00 (NON REFUNDABLE)** DO NOT STAPLE CHECK TO FORM.
A $20.00 fee will be charged for payment returned by bank.	**This form is invalid after 10/31/2016; late fees are assessed.**

☐ I will not be practicing this profession in Pennsylvania and request inactive status. No fee is required.

☐ I have a change of name and/or address. **Complete section below and indicate Social Security #:**_____

Name Change	**Address Change** - Please print
Submit a photocopy of a legal document verifying name change (i.e., marriage certificate, divorce decree or court order). Name will not be changed without submission of document.	
PRINT NEW NAME:	

Continuing Education Requirement: You are required to complete a minimum of 30 hours of Board-approved continuing education during the period November 1, 2014, and October 31, 2016. Of the 30 hours, 2 hours of continuing education in child abuse recognition and reporting shall be completed for renewal. Your license will not be renewed if you have not completed the entire continuing education requirement. In the event you are audited, you will be required to produce documentation of the continuing education.

THE FOLLOWING QUESTIONS MUST BE ANSWERED or this application will be returned.

If you answer yes to question 6, provide copies of all disciplinary actions from the Boards that imposed actions and a personal detailed statement.	**Yes**	**No**
1. Are you submitting a name change with this renewal?		
2. Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?		
3. Have you completed a minimum of 30 hours of Board-approved continuing education? **Do not send materials now.** The Board will conduct an audit at a later date.		
4. Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?		
5. If you answered yes to the above question, please provide the profession and state or jurisdiction.		
6. **Since your initial application or last renewal, whichever is later**, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		

If you answer yes to questions 7 through 14, provide copies of pertinent documents and a personal detailed statement.	**Yes**	**No**
7. Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
8. **Since your initial application or last renewal, whichever is later**, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
9. **Since your initial application or last renewal, whichever is later**, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.		
10. Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?		
11. **Since your initial application or your last renewal, whichever is later**, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
12. **Since your initial application or your last renewal, whichever is later**, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?		
13. **Since your initial application or your last renewal, whichever is later**, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
14. **Since your initial application or last renewal, whichever is later**, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		

Your license cannot be renewed if you have not completed the Board-approved continuing education. The Board will audit a percentage of licensees for compliance with the 30-hour requirement. In the event you are audited, you will be required to produce documentation of the continuing education.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa. C.S. §4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. §4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Signature of Licensee **(Mandatory)**: _____ Date _____