Wyoming Healthcare Commission
Advanced Practice Nursing Workforce Study

Please assist the Wyoming Healthcare Commission in updating your Advance Practice Nursing profile. **Review and make any corrections or additions necessary.** Please Return by 08/07/2007 in the envelope provided or fax toll-free to (877) 290-0014. If you have any questions, please contact Rita toll-free at (877) 290-0021. Thank you.

SECTION I:

Name: ______________________ **Wyoming License #:** ______________

Home Address: ______________________ **UPIN:** ______________

(Address)

______________________ **NPI:** ______________

(City) *(State)* *(Zip)*

Preferred Mailing Address: ☐ Home ☐ Primary Office

Email Address: ______________________

Date of Birth: ______________ **Birthplace State & Country:** ______________

Date you began practicing in Wyoming: __________

Primary Specialty:

☐ Acute Care Nurse Practitioner ☐ Clinical Specialist-Acute Care ☐ Family Nurse Practitioner ☐ Psychiatric Mental Health NP
☐ Adult Nurse Practitioner ☐ Clinical Specialist-Community Health ☐ Geriatric Nurse Practitioner ☐ WHCNP
☐ Certified Nurse Anesthetist ☐ Clinical Specialist-Med.-Surg. ☐ Neonatal Nurse Practitioner ☐ Other: __________
☐ Certified Nurse Midwife ☐ Clinical Specialist-Psych./Mental Health ☐ Pediatric Nurse Practitioner

Are you certified? ☐ NO ☐ YES **If yes, certifying body:** ______________

Certification #: ______________ **Expiration Date:** ______________

Overall Work Status in Wyoming: ☐ Full-time (>= 40 hrs/wk) ☐ Part-time (<= 29 hrs/wk) ☐ Retired ☐ Inactive ☐ Unemployed and seeking work
☐ Locum Tenens ☐ Part-Time (30-39 hrs/wk) ☐ Not practicing in Wyoming ☐ Working in another field

Ethnic Background: ☐ African American ☐ Caucasian/White ☐ Japanese ☐ Other Pacific Islander
☐ Alaskan Native ☐ Chinese ☐ Korean ☐ SE Asian
☐ American Indian ☐ Filipino ☐ Native Hawaiian ☐ Vietnamese
☐ Asian Indian ☐ Hispanic or Latino ☐ Other Asian ☐ Other: __________

Gender: ☐ Female ☐ Male

Languages Spoken Fluently: ☐ English ☐ Spanish ☐ Other ______________

Did you live in Wyoming as a child? ☐ No ☐ Yes **Did you live in a rural area as a child?** ☐ No ☐ Yes

SECTION II: Educational Background

High School: City: ______________ State: ______ Country: __________

Basic Nursing Education

School: ______________________

City: __________ State: ______ Country: __________

☐ Diploma ☐ Associate ☐ BSN ☐ MSN ☐ Generic ND

Year Completed: ______

Other Nursing Education

School: ______________________

City: __________ State: ______ Country: __________

☐ BSN ☐ MSN ☐ Generic ND ☐ PhD-Nursing ☐ DNP

Year Completed: ______

Advanced Practice Nursing Preparation

School: ______________________

City: __________ State: ______ Country: __________

☐ Certificate Program ☐ MSN ☐ Post Masters Cert. ☐ DNP

Area of Specialization: __________ Year Completed: ______

Other Nursing Education

School: ______________________

City: __________ State: ______ Country: __________

☐ BSN ☐ MSN ☐ Generic ND ☐ PhD-Nursing ☐ DNP

Year Completed: ______

Other Degrees: ☐ Non-Nursing Baccalaureate ☐ Non-Nursing Masters ☐ Non-Nursing PhD

Highest Degree Held: ______________ Year Completed: ______

School: ______________ State: __________

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SECTION III: Health Alerts The information collected in this section (i.e., fax, email address, and telephone) is confidential and will be used only for health alert or public health related communications. **Please fill-in the necessary information and indicate your preferred preference with which to be contacted in the event of a public health crisis.**
(1 = Preferred method, 2 = Second choice, 3 = Last choice)

__ **Fax:** ______________________ __ **E-mail:** __________________________________ __ **Telephone:** ______________________

SECTION IV: Research Issues

1. **Have you ever participated in any of the programs listed below?** ☐ No ☐ Yes *(If yes, please check all that apply)*
   ☐ Federal Nurse Traineeship ☐ Health Care Facility ☐ Military/GI Bill ☐ US Public Health Service ☐ WICHE ☐ WY State Loan
   ☐ Federal Scholarship ☐ Indian Health Service ☐ NHSC Loan ☐ VA ☐ WUI ☐ WYIN
   Have you completed your training? ☐ No ☐ Yes

2. **Currently, do you have privileges at a Wyoming hospital?** ☐ No ☐ Yes
   a) If yes, please list hospital(s): ____

3. **Are you currently serving in or have a commitment to the U.S. military?** ☐ Not Applicable ☐ Active Duty ☐ IRR ☐ Reserves
   a) If so, which branch of service? ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ National Guard ☐ Navy ☐ Other

***Note Questions 4 - 7** These questions apply to your primary **Wyoming** practice only, even if your "primary" practice setting is in another state.

4. **In an average week, approximately how many hours do you spend on call?** _____ hours

5. **In the past 12 months, have you ceased offering specific services due to increased malpractice premiums?** ☐ No ☐ Yes
   a) If yes, please specify: ____
   ____

6. **In the past 12 months, have you ceased offering specific services due to other reasons?** ☐ No ☐ Yes
   a) If yes, please explain: ____
   ____

7. **In the past 12 months, have you added a service(s) to your practice?** ☐ No ☐ Yes
   a) If yes, please define additional service(s): ____
   ____

8. **What are your plans for retirement?** *(Please select one)*
   ☐ In less than one year ☐ In the next 3-5 years ☐ More than 10 years from now
   ☐ In the next 1-2 years ☐ In the next 6-10 years ☐ Don't know/Not sure

9. **Do you plan to change your practice in Wyoming?** ☐ No ☐ Yes *(If Yes, please specify change and timeframe.)*
   Relocate within Wyoming _______ Relocate outside of Wyoming ______ Stop patient care ______
   ☐ In less than one year ☐ In the next 3-5 years ☐ More than 10 years from now
   ☐ In the next 1-2 years ☐ In the next 6-10 years ☐ Don't know/Not sure

10. **If Yes to #9, please check all of the issues related to this decision:**
   ☐ Departmental issues ☐ Isolation ☐ Personal
   ☐ Inability to obtain hospital privileges ☐ Lack of appropriate call coverage ☐ 3rd Party payers
   ☐ Income ☐ Malpractice rates ☐ Restriction of practice
   ☐ Insufficient time for CEU/CME ☐ Patient load too heavy ☐ Physician relationship
   ☐ Insufficient vacation time ☐ Patient load too light ☐ Other: (Please specify) ____________________

11. **Please feel free to provide any additional comments below:**

____
____
____
____

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SECTION V: Practice Locations

Please complete the following information for ALL of your practice locations, i.e., primary, satellite, research, administration, etc.
Please make additional copies of this page, as needed, to provide information on all of your practice locations.

Primary Practice Information

Practice Name: ______________________________

Your specialties at this practice location: *(Select all that apply)*

☐ Acute Care Nurse Practitioner ☐ Clinical Specialist-Acute Care ☐ Family Nurse Practitioner ☐ Psychiatric Mental Health NP
☐ Adult Nurse Practitioner ☐ Clinical Specialist-Community Health ☐ Geriatric Nurse Practitioner ☐ WHCNP
☐ Certified Nurse Anesthetist ☐ Clinical Specialist-Med.-Surg. ☐ Neonatal Nurse Practitioner ☐ Other
☐ Certified Nurse Midwife ☐ Clinical Specialist-Psych./Mental Health ☐ Pediatric Nurse Practitioner ______________

Address: ______________________________

City: ______________ **State:** ________ **Zip:** ____________

Appointment Telephone: ______________ **Fax:** ______________

On average, how many hours do you work at this site per week? ________ **hours**

In an average week, approximately how many hours do you spend in each of the activities listed below?

__ Administrative/Managerial __ Providing Direct Out-patient Care __ Teaching/Precepting
__ Providing Direct In-patient Care __ Research __ Supervising Students

What best describes the patient activity at this practice? *(Please select one)*

☐ Accepting new Medicaid patients ☐ Accepting new Medicare patients ☐ Not seeing patients
☐ Actively seeking new patients ☐ Currently accepting new patients ☐ Unable to accept new patients *(Please explain)*

How would you best describe this practice arrangement? *(Please select one)*

☐ Contract Employee ☐ Salaried - Group Health Plan ☐ Salaried - State Government ☐ Volunteer
☐ Hourly Employee ☐ Salaried - Hospital (Non-Federal) ☐ Self-Employed - Partnership or Group ☐ Locum Tenens
☐ Salaried - Federal Government ☐ Salaried - Military ☐ Self-Employed - Solo Practice ☐ Other ______________

Which of the following best describes this practice setting? *(Choose between the two headings and then select one)*

Direct Patient Care:

☐ Alcohol/Detox/Halfway House ☐ Home Health Care ☐ Long-Term Care Facility ☐ Specialty Hospital
☐ Assisted Living ☐ Hospital (Non-Federal) ☐ Military Facility ☐ State Institution
☐ Clinic (Free-standing) ☐ Indian Health Services ☐ Outpatient Surgery Center ☐ Urgent Care
☐ Clinic (Hospital) ☐ Industrial/Occupational Health Clinic ☐ Public Health ☐ VA Facility
☐ Community Health Center ☐ Rural Health Clinic Federally-qualified

Administrative/Other:

☐ Administrative Agency
☐ Group Health Plan
☐ Insurance Company
☐ Research
☐ School/University

Thank You.

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