Wyoming Healthcare Commission
Physician Workforce Study

Please assist the Wyoming Healthcare Commission in updating your Physician profile. **Review and make any corrections or additions necessary.** Please Return by 11/01/2007 in the envelope provided or fax toll-free (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 WY: ______________ **Primary Specialty:** ______________

Additional Specialized Expertise/Special Procedures: ______________

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

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 ______________

SECTION II: **Educational Background**

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

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

Undergraduate Education

School: ______________

City: ______________ State: ______ Country: ______________

Year Completed: ______ Degree Type: ______________

Medical School

School: ______________

City: ______________ State: ______ Country: ______________

Year Completed: ______

Internship/Residency/Fellowship/Other *(Please Circle One)*

School: ______________

City: ______________ State: ______ Country: ______________

Specialty: ______________

Year Completed: ______ Currently Board Certified: No / Yes

Internship/Residency/Fellowship/Other *(Please Circle One)*

School: ______________

City: ______________ State: ______ Country: ______________

Specialty: ______________

Year Completed: ______ Currently Board Certified: No / Yes

Internship/Residency/Fellowship/Other *(Please Circle One)*

School: ______________

City: ______________ State: ______ Country: ______________

Specialty: ______________

Year Completed: ______ Currently Board Certified: No / Yes

Internship/Residency/Fellowship/Other *(Please Circle One)*

School: ______________

City: ______________ State: ______ Country: ______________

Specialty: ______________

Year Completed: ______ Currently Board Certified: No / Yes

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 as a student? ☐ No ☐ Yes *(If yes, please check all that apply)*

a) If yes, have you completed your training? ☐ No ☐ Yes

☐ Conrad 30 ☐ NHSC Loan ☐ WICHE ☐ WY State Loan

☐ J-1 Visa ☐ NHSC Scholar ☐ WWAMI ☐ WY State Contract Med Education Program(Creighton, Utah)

2. Have you ever participated in any of the programs listed below as a preceptor? ☐ No ☐ Yes *(If yes, please check all that apply)*

☐ Conrad 30 ☐ NHSC Loan ☐ WICHE ☐ WY State Loan

☐ J-1 Visa ☐ NHSC Scholar ☐ WWAMI ☐ WY State Contract Med Education Program(Creighton, Utah)

3. Currently, do you have privileges at a Wyoming hospital? ☐ No ☐ Yes

a) If yes, please list hospital(s): _____

4. Are you currently serving in or have a commitment to the U.S. military? ☐ NA ☐ Active Duty ☐ IRR ☐ Reserves

a) If so, which branch of service? ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ National Guard ☐ Navy ☐ Other

***Note Questions 5 - 9** *These questions apply to your primary **Wyoming** practice only, even if your "primary" practice setting is in another state.*

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

6. In the past 12 months, have you ceased offering specific services due to increased malpractice premiums? ☐ No ☐ Yes

a) If yes, please specify: _____

_____

7. In the past 12 months, have you ceased offering specific services due to other reasons? ☐ No ☐ Yes

a) If yes, please explain: _____

_____

8. In the past 12 months, have you added a service(s) to your practice? ☐ No ☐ Yes

a) If yes, please define additional services: _____

_____

9. Do you have sufficient access to ancillary and specialty services? ☐ No ☐ Yes

a) If no, please explain: _____

_____

10. 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

11. 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

12. If Yes to #11, please check all of the issues related to this decision:

☐ Departmental issues ☐ Isolation ☐ Patient load too light

☐ Income ☐ Lack of appropriate call coverage ☐ Personal

☐ Insufficient time for CEU/CME ☐ Malpractice rates ☐ 3rd Party payers

☐ Insufficient vacation time ☐ Patient load too heavy ☐ Other: (Please specify) _____

13. Please feel free to provide any additional comments below:

_____

_____

_____

_____

SECTION V: Practice Locations

Please complete the following information for ALL of your practice locations, i.e., primary, satellite, medical directory, research, county public health officer, county coroner, 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: _____ **Specialty:** _____

Address: _____ **Sub Specialty:** _____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____ **Fax:** _____

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

What best describes the patient activity at this practice location?

☐ 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)*

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 ___ Research

___ Supervising Mid-levels ___ Providing Direct in-patient Care ___ Teaching/Precepting

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

☐ Hourly Employee ☐ Salaried - Hospital (Non-Federal) ☐ Salaried - State Government

☐ Locum Tenens ☐ Salaried - Military ☐ Volunteer

☐ Salaried - Federal Government ☐ Self-Employed - Partnership or Group ☐ Other _____

☐ Salaried - Group Health Plan ☐ Self-Employed - Solo Practice

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
☐ Clinic (Free-standing)
☐ Clinic (Hospital)
☐ Community Health Center
☐ Hospital (Non-Federal)
☐ Indian Health Services
☐ Industrial/Occupational Health Clinic
☐ Long-term Care Facility
☐ Military Facility
☐ Outpatient Surgery Center
☐ Public Health
☐ Rural Health Clinic (Federally-qualified)
☐ Specialty Hospital
☐ State Institution
☐ Urgent Care
☐ VA Facility

Administrative/Other:

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

Thank You.