Wyoming Healthcare Commission
Physician Assistant Workforce Study

Please assist the Wyoming Healthcare Commission in updating your Physician Assistant profile. **Review and make any corrections or additions necessary.** Please Return by 11/01/2007 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 WY: _____

Primary Specialty:

☐ Cardiology	☐ General Surgery	☐ OB/GYN	☐ Urology
☐ Correctional Medicine	☐ Geriatric Medicine	☐ Orthopedics	☐ Pediatric Specialty
☐ Emergency Medicine	☐ Industrial Medicine	☐ Pediatrics	☐ Surgical Specialty
☐ Family Medicine	☐ Internal Medicine	☐ Psychiatry	☐ Other: _____
☐ Gastroenterology	☐ Neurology	☐ Radiology	

Overall Work Status in Wyoming:

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

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: _____

Postgraduate Education

School: _____
City: _____ State: _____ Country: _____
Area of Study: _____
Year Completed: _____ Degree Type: _____

PA Program

School: _____
City: _____ State: _____ Country: _____
Year Completed: _____ Degree Type: _____

Postgraduate Education

School: _____
City: _____ State: _____ Country: _____
Area of Study: _____
Year Completed: _____ Degree Type: _____

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

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

☐ NHSC Loan ☐ NHSC Scholar ☐ WICHE ☐ WWAMI ☐ WY State Loan

Have you ever participated in any of the programs listed below as a preceptor? ☐ No ☐ Yes

☐ NHSC Loan ☐ NHSC Scholar ☐ WICHE ☐ WWAMI ☐ WY State Loan

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? ☐ NA ☐ Active Duty ☐ IRR ☐ Reserves

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

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

***Note Questions 5 - 7** *These questions apply to your primary **Wyoming** practice only, even if your "primary" practice setting is in another state.*

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 services: _____

_____

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 ☐ 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) _____

11. 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, 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 specialty at this practice location? *(Please select one)*

☐ Cardiology	☐ General Surgery	☐ OB/GYN	☐ Urology
☐ Correctional Medicine	☐ Geriatric Medicine	☐ Othopedics	☐ Pediatric Specialty
☐ Emergency Medicine	☐ Industrial Medicine	☐ Pediatrics	☐ Surgical Specialty
☐ Family Medicine	☐ Internal Medicine	☐ Psychiatry	
☐ Gastroenterology	☐ Neurology	☐ Radiology	

Supervising Physician(s) **Primary:** _____ **Secondary:** _____

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

What best describes the patient activity at this practice location?

☐ Accepting new Medicaid patients ☐ Actively seeking new patients ☐ Not seeing patients
☐ Accepting new Medicare 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	☐ Other _____
☐ Salaried - Federal Government	☐ Salaried - Military	☐ 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	☐ Industrial/Occupational Health Clinic	☐ Rural Health Clinic (Federally-qualified)	☐ Administrative Agency
☐ Clinic (Free-standing)	☐ Long-term Care Facility	☐ Specialty Hospital	☐ Group Health Plan
☐ Clinic (Hospital)	☐ Military Facility	☐ State Institution	☐ Insurance Company
☐ Community Health Center	☐ Outpatient Surgery Center	☐ Urgent Care	☐ Research
☐ Hospital (Non-Federal)	☐ Public Health	☐ VA Facility	☐ School/University
☐ Indian Health Services			

Administrative/Other:

Thank You.