



The Office of Rural Health and Primary Care at the Minnesota Department of Health would like you to take a few minutes and complete the attached health care professional data form. **Your participation is essential in developing accurate, useful information.** If you need assistance filling out this form please call (651) 282-3838 or Toll Free (800) 366-5424.

The information collected through the survey will help to identify worker shortages and improve access to health care across the state. The Office of Rural Health and Primary Care is required to collect this information for the Department of Health in accordance with Minnesota Statute, section 144.052 and Minnesota Rule 4695.0030.

*Failure to provide this information will not affect your renewal.* This information is classified as public and is used to improve access to health care. However, Minnesota Statute, section 144.1485, allows you to request that your practice addresses be classified as private if this classification is required for your safety.

**SECTION A: TRAINING AND PROFESSIONAL INFORMATION**

1. Please describe your post-secondary educational background (*check highest level attained*).

- Diploma       Associate degree       Bachelors degree       Master's degree       Doctorate

2. Did you obtain your physician assistant training in Minnesota?  Yes       No

3. Which of the following choices best describes your current professional status? (*Check only ONE*).

- a. Working in a paid position as a physician assistant.
- b. Working in an unpaid position as a physician assistant.
- c. Retired.
- d. Not currently working due to family or medical reasons.
- e. Employed in another field seeking work as a physician assistant.
- f. Employed in another field not seeking work as a physician assistant.
- g. Unemployed seeking work as a physician assistant.
- h. Student (*specify major*) \_\_\_\_\_

**If you checked either (a) or (b) above, complete Sections B, and D below.**

**If you selected any of (c) through (h) above, please proceed directly to Section D on next page.**

**SECTION B: EMPLOYMENT INFORMATION**

**IMPORTANT: Please provide information about the sites where you work the most hours. The hours you work at a site may vary greatly from week to week. Provide your BEST ESTIMATE of the hours you work at each site in a typical week. Please do not respond by giving a range of hours (e.g., 10-20 hours).**

4. What type of facility is your **primary** practice site? (*Check only ONE*).

a. Office/Clinic       b. Hospital - inpatient       c. Hospital - outpatient       d. Rehab agency

e. Home health agency       f. Long term care agency       g. Other (specify) \_\_\_\_\_

5. Number of hours you work in a **TYPICAL WEEK** at this practice site \_\_\_\_\_ (*On average*)

6. What type of facility is your **secondary** practice site? (*If applicable. Check only ONE*).

a. Office/Clinic       b. Hospital - inpatient       c. Hospital - outpatient       d. Rehab agency

e. Home health agency       f. Long term care agency       g. Other (specify) \_\_\_\_\_

7. Number of hours you work in a **TYPICAL WEEK** at this practice site \_\_\_\_\_ (*On average*)

**SECTION C: PRACTICE INFORMATION**

**8.** What professional activity accounts for the largest share of your work-time?

- a. Patient Care     b. Administration     c. Teaching  
 d. Research     e. Consultant     f. Supervisor/  
Coordinator     g. Sales  
 h. Other (specify) \_\_\_\_\_

(Check only **ONE**).

**9.** What professional activity accounts for the second largest share of your work-time?

- a. Patient Care     b. Administration     c. Teaching  
 d. Research     e. Consultant     f. Supervisor/  
Coordinator     g. Sales  
 h. Other (specify) \_\_\_\_\_

(Check only **ONE**).

**10.** Total number of hours devoted **EACH WEEK** to DIRECT PATIENT CARE \_\_\_\_\_ (On average)

**SECTION D: RACE AND ETHNICITY INFORMATION (OPTIONAL)**

**11.** Check **one or more** boxes that best describe your race or ethnic group.

- a. White     d. American Indian or Alaska Native  
 b. Black or African American     e. Hispanic, Latino or Spanish origin  
 c. Asian/Pacific Islander     f. Other (please specify) \_\_\_\_\_

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**Return this form with your registration information.**

**Physician Assistant 2005**