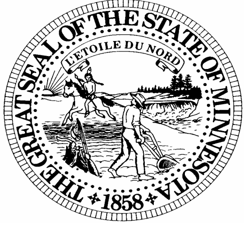

The Office of Rural Health and Primary Care at the Minnesota Department of Health would like you to take a few minutes and complete the attached health care professional data form. ***Your participation is essential in developing accurate, useful information.*** If you need assistance filling out this 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: APPLICANT INFORMATION

Registered Nurse license number: ___________________ Daytime phone number: (____) ______________________

First Name ______________________ Middle Initial _____ Last Name ______________________________________

Check ***one or more*** boxes that best describe your race or ethnic group. (***Optional***)

- ☐ 1. White
- ☐ 2. Black or African American
- ☐ 3. Asian/Pacific Islander
- ☐ 4. American Indian or Alaska Native
- ☐ 5. Hispanic, Latino or Spanish origin
- ☐ 6. Other *(please specify)* ________________________________

SECTION B: EMPLOYMENT INFORMATION

1a. Are you working in a position that requires you to keep your nursing license current?

- ☐ **Yes**
  - If yes, are you:
  - ☐ On a leave of absence?
  - ☐ Unpaid volunteer?
- ☐ **No**

If you answered "**YES**" or "**leave of absence**" or "**unpaid volunteer**," complete the rest of the survey.

If you answered "**NO,**" ***only*** complete **Question 1b**.

1b. Which of the following choices best describes your current professional status? *(Fill in only **ONE**).*

- ☐ 1. Retired.
- ☐ 2. Not currently working due to family or medical reasons.
- ☐ 3. Employed in another field seeking work as a registered nurse.
- ☐ 4. Employed in another field not seeking work as a registered nurse.
- ☐ 5. Unemployed, seeking work as a registered nurse.
- ☐ 6. Student *(specify major)*______________________
- ☐ 7. Other *(specify)*____________________________

SITE ONE

2. Complete the following information about where you are either employed as a registered nurse or in a job that requires a current nursing license. **This site is where you work the *majority* of your hours weekly.**

2a. Agency, company or facility name ____

Street Address ____________________________ City ________________________ State ______ Zip code_________

2b. Current job title *(if other than **Registered Nurse**)* ____

2c. Number of years you have worked at this facility ___________ For this employer _____________

2d. How many hours do you work as a nurse in a typical **WEEK**? (*Do not count on-call hours.)* ______ (average hours per **WEEK**)

2e. How many hours do you **provide** OR **supervise** direct patient care in a typical **WEEK**? ______ (average hours per **WEEK**)

2f. What type of facility/employer is this? (*Check only **ONE**)*

- ☐ 1. Hospital-Inpatient
- ☐ 2. Hospital-Outpatient
- ☐ 3. Non-hospital Outpatient
- ☐ 4. Clinic/Provider Office
- ☐ 5. Nursing Home
- ☐ 6. Home Health Agency
- ☐ 7. Public Health Agency
- ☐ 8. Rehabilitation Facility
- ☐ 9. School/College/University
- ☐ A. Independent Practice
- ☐ B. Insurance/Utilization
- ☐ C. Other _____________

2g. What type of department/unit/area do you work in at this facility/employer? (*Check only **ONE**)*

- ☐ 1. Medical/Surgical
- ☐ 2. Operating Room/Recovery
- ☐ 3. Intensive Care
- ☐ 4. Psychiatric/Behavioral
- ☐ 5. Obstetric/Gynecologic
- ☐ 6. Emergency
- ☐ 7. Public Health
- ☐ 8. Home Care
- ☐ 9. School Health Services
- ☐ A. Education/Research
- ☐ B. Long-term/Assisted Care
- ☐ C. Other _____________

2h. What is your primary professional activity at this facility/employer? (*Check only **ONE**)*

- ☐ 1. Provide patient care
- ☐ 2. Administration
- ☐ 3. Supervise patient care
- ☐ 4. Insurance/Utilization
- ☐ 5. Case Management
- ☐ 6. Teaching
- ☐ 7. Telephone Triage
- ☐ 8. Other _____________

Please return this form with your license renewal.

SITE TWO

3. Complete the following information about where you are either employed as a registered nurse or in a job that requires a current nursing license. **This site is where you work the *second* highest number of hours weekly**

3a. Agency, company or facility name ______________________________

Street Address ____________________ City ____________________ State ______ Zip code_________

3b. Current job title *(if other than **Registered Nurse**)* ______________________________

3c. Number of years you have worked at this facility ___________ For this employer _____________

3d. How many hours do you work as a nurse in a typical **WEEK**? (*Do not count on call hours.)* ______ (average hours per **WEEK)**

3e. How many hours do you **provide** OR **supervise** direct patient care in a typical **WEEK**? ______ (average hours per **WEEK)**

3f. What type of facility/employer is this? (*Check only **ONE)***

- ☐ 1. Hospital-Inpatient
- ☐ 2. Hospital-Outpatient
- ☐ 3. Non-hospital Outpatient
- ☐ 4. Clinic/Provider office
- ☐ 5. Nursing Home
- ☐ 6. Home health agency
- ☐ 7. Public health agency
- ☐ 8. Rehabilitation facility
- ☐ 9. School/College/University
- ☐ A. Independent practice
- ☐ B. Insurance/Utilization
- ☐ C. Other _________________

3g. What type of department/unit/area do you work in at this facility/employer? (*Check only **ONE)***

- ☐ 1. Medical/Surgical
- ☐ 2. Operating Room/Recovery
- ☐ 3. Intensive care
- ☐ 4. Psychiatric/Behavioral
- ☐ 5. Obstetric/Gynecologic
- ☐ 6. Emergency
- ☐ 7. Public Health
- ☐ 8. Home Care
- ☐ 9. School Health Services
- ☐ A. Education/Research
- ☐ B. Long-term/Assisted Care
- ☐ C. Other ______________

3h. What is your primary professional activity at this facility/employer? (*Check only **ONE)***

- ☐ 1. Provide patient care
- ☐ 2. Administration
- ☐ 3. Supervise patient care
- ☐ 4. Insurance/Utilization
- ☐ 5. Case Management
- ☐ 6. Teaching
- ☐ 7. Telephone Triage
- ☐ 8. Other __________________

SECTION C: ADVANCED PRACTICE EDUCATION AND TRAINING INFORMATION

Complete this section **ONLY** if **you are** certified as an advanced practice registered nurse.

4. Indicate **(A)** the category in which you are certified, **(B)** the year the certificate was received, (C) the institution from which you received the educational preparation, and **(D)** if you currently practice in this advanced practice category. (*Fill in **ALL** that apply)*

A. Advanced Practice Category	**B.** Year Certification was Received	**C.** Institution Name and State *(Example: College of St. Catherine, MN)*	**D.** Currently Practicing in Advanced Practice Category?
☐ Certified Nurse Practitioner	___________	______________________	☐ Yes ☐ No
☐ Certified Clinical Nurse Specialist	___________	______________________	☐ Yes ☐ No
☐ Certified Nurse-Midwife	___________	______________________	☐ Yes ☐ No
☐ Certified Registered Nurse Anesthetist	___________	______________________	☐ Yes ☐ No

5. If you are a certified and practicing **Certified Nurse Practitioner**, identify which certification area(s) you currently practice in.
(*Fill in **ALL** that apply)*

- ☐ 1. Acute Care
- ☐ 2. Adult
- ☐ 3. Family
- ☐ 4. Gerontology
- ☐ 5. Neonatal
- ☐ 6. Pediatric
- ☐ 7. Psychiatric Mental Health
- ☐ 8. School
- ☐ 9. Women's Health (OB/GYN)
- ☐ A. Other ________________________

6. If you are a certified and practicing **Certified Clinical Nurse Specialist**, identify which certification area(s) you currently practice in.
(*Fill in **ALL** that apply)*

- ☐ 1. Adult Critical Care
- ☐ 2. Adult Psychiatric and Mental Health
- ☐ 3. Child/Adolescent Psychiatric and Mental Health
- ☐ 4. Community Health
- ☐ 5. Diabetes Management
- ☐ 6. Gerontological
- ☐ 7. Home Health
- ☐ 8. Medical-Surgical
- ☐ 9. Neonatal Critical Care
- ☐ A. Pediatric
- ☐ B. Pediatric Critical Care
- ☐ C. Other ________________________

Office of Rural Health and Primary Care
Minnesota Department of Health
P.O. Box 64882
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(651) 282-3838 or Toll Free (800) 366-5424

Please return this form with your license renewal.