



INDIANA UNIVERSITY

SCHOOL OF MEDICINE

Bowen Center for Health Workforce Research and Policy

2020 Pharmacist Re-Licensure Survey Instrument

1. Sex
 - a. Male
 - b. Female

2. Ethnicity: Are you Hispanic or Latino?
 - a. Yes
 - b. No

3. Race (Check all that apply.)
 - a. American Indian or Alaska Native
 - b. Black or African American
 - c. White
 - d. Asian
 - e. Native Hawaiian or Other Pacific Islander
 - f. Some other race

4. What type of degree/credential qualified you for your first U.S. pharmacist license?
 - a. RADIO BUTTONS
 - b. Certificate
 - c. Associate
 - d. Bachelors
 - e. Masters
 - f. Doctor of Pharmacy

5. Where did you complete your pharmacist education that first qualified you for your U.S. pharmacist license?
 - a. DROP DOWN LIST
 - i. Indiana
 - ii. Michigan
 - iii. Illinois
 - iv. Kentucky
 - v. Ohio
 - vi. Another State (not listed)
 - vii. Another Country (not U.S.)

6. What year did you complete the pharmacist education that first qualified you for your U.S. pharmacist license? Please indicate using the four digit year.
 - a. TEXT BOX

7. Have you completed a pharmacy fellowship?

RADIO BUTTONS

 - a. Yes

b. No

8. If you have completed a residency, in which specialty was your residency program? If you did not complete a residency, if this does not apply, please indicate "Not Applicable"

CHECK BOXES

- a. No Residency Completed
- b. Ambulatory Care
- c. Cardiology
- d. Critical Care
- e. Drug Information
- f. Emergency Medicine
- g. Geriatric
- h. Infectious Diseases
- i. Informatics
- j. Internal Medicine
- k. Managed Care Pharmacy Systems
- l. Medication-Use Safety
- m. Nuclear
- n. Nutrition Support
- o. Oncology
- p. Pediatric
- q. Pharmacotherapy
- r. Health-System Pharmacy Administration
- s. Psychiatric
- t. Solid Organ Transplant
- u. Not Applicable

9. If you have a BPS certification, in which specialty is your certification? If you do not have a BPS certification, please indicate "Not Applicable"

DROP DOWN

- a. No BPS Certification
- b. Ambulatory Care Pharmacy
- c. Critical Care Pharmacy
- d. Nuclear Pharmacy
- e. Nutrition Support Pharmacy
- f. Oncology Pharmacy
- g. Pediatric Pharmacy
- h. Pharmacotherapy
- i. Psychiatric Pharmacy
- j. Not Applicable

10. What is your employment status?

- a. RADIO BUTTONS OR DROP DOWN
- b. Actively working in a position that requires a pharmacist license
- c. Actively working in a pharmacy related field that does not require a pharmacist license
- d. Actively working in a field that does not require a pharmacist license
- e. Not currently working, disabled

- f. Not currently working, seeking work in a position that requires a pharmacist license
- g. Not currently working, seeking work in a position that does not require a pharmacist license
- h. Student
- i. Leave of absence or Sabbatical
- j. Retired

11. What are your employment plans for the next 12 months?

- a. RADIO BUTTONS
- b. Increase hours in the pharmacy field
- c. Decrease hours in the pharmacy field
- d. Leave employment in the field of pharmacy
- e. No planned change

12. How many weeks did you work as a pharmacist in the past year? Please approximate and enter a number 0 through 52 (no decimals).

- i. TEXT BOX

13. Please indicate in which field you spend the majority of your time. If this does not apply, please select “not applicable.”

- a. DROP-DOWN LIST OR RADIO BUTTONS
- b. Medication Dispensing
- c. Patient Care Services
- d. Business/Organization Management
- e. Research
- f. Education
- g. Other
- h. Not applicable

14. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select “N/A”

DROP-DOWN LIST (including N/A)

15. If located in Indiana, what is the county of your primary practice location? If this does not apply, please indicate “N/A” _____ (free text)

16. If located in Indiana, what is the zip code of your primary practice location? If this does not apply, please indicate “N/A” _____ (free text)

17. How many total hours do you spend per week at your primary practice location? If this does not apply, please select “not applicable.”

DROP-DOWN LIST OR RADIO BUTTONS

- a. 0 hours per week
- b. 1 – 4 hours per week
- c. 5 – 8 hours per week
- d. 9 – 12 hours per week

- e. 13 – 16 hours per week
- f. 17 – 20 hours per week
- g. 21 – 24 hours per week
- h. 25 – 28 hours per week
- i. 29 – 32 hours per week
- j. 33 – 36 hours per week
- k. 37 – 40 hours per week
- l. 41 or more hours per week
- m. Not Applicable

18. Please approximate the percentage of your time that you spend providing patient care services at your primary practice location (**excluding** medication dispensing, education, research, and business activities).

DROP DOWN

- a. 0%
- b. 10%
- c. 20%
- d. 30%
- e. 40%
- f. 50%
- g. 60%
- h. 70%
- i. 80%
- j. 90%
- k. 100%

19. Please identify the type of setting that most closely corresponds to your primary practice position. If this does not apply, please select “Not Applicable”

DROP DOWN

- Community Health Center/Public Health Clinic
- Diagnostic Testing Facility
- Emergency Room
- Hospital (Inpatient)
- Long Term Acute Care Hospital
- Outpatient Clinic (Private Practice or Academic)
- Outpatient Surgery Center
- Pain Management Clinic
- Pharmacy (Inpatient)
- Pharmacy (Outpatient)
- Rehabilitation Hospital
- Retail Medicine Clinic (CVS Minute Clinic, Walgreens Healthcare Clinic, Clinic at Wal-Mart)
- Substance Abuse Treatment Facility (Inpatient)
- Urgent Care Facility
- Other

Not Applicable

20. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"

DROP-DOWN LIST including N/A

21. If located in Indiana, what is the county of your secondary practice location? If this does not apply, please indicate "N/A" _____ (free text)

22. If located in Indiana, what is the zip code of your secondary practice location? If this does not apply, please indicate "N/A" _____ (free text)

23. How many hours do you spend per week at your secondary practice location? If this does not apply, please indicate "Not Applicable."

DROP-DOWN LIST OR RADIO BUTTONS

- a. 0 hours per week
- b. 1 – 4 hours per week
- c. 5 – 8 hours per week
- d. 9 – 12 hours per week
- e. 13 – 16 hours per week
- f. 17 – 20 hours per week
- g. 21 – 24 hours per week
- h. 25 – 28 hours per week
- i. 29 – 32 hours per week
- j. 33 – 36 hours per week
- k. 37 – 40 hours per week
- l. 41 or more hours per week
- m. Not Applicable

24. Please approximate the percentage of your time that you spend providing patient care services at your secondary practice location (excluding medication dispensing, education, research, and business activities). If this does not apply, please indicate "Not Applicable."

DROP DOWN

- a. 0%
- b. 10%
- c. 20%
- d. 30%
- e. 40%
- f. 50%
- g. 60%
- h. 70%
- i. 80%
- j. 90%
- k. 100%
- l. Not Applicable

25. Please identify the type of setting that most closely corresponds to your secondary practice location. If this does not apply, please indicate "Not Applicable."

DROP DOWN

- a. DROP DOWN
- b. Community Health Center/Public Health Clinic
- c. Diagnostic Testing Facility
- d. Emergency Room
- e. Hospital (Inpatient)
- f. Long Term Acute Care Hospital
- g. Outpatient Clinic (Private Practice or Academic)
- h. Outpatient Surgery Center
- i. Pain Management Clinic
- j. Pharmacy (Inpatient)
- k. Pharmacy (Outpatient)
- l. Rehabilitation Hospital
- m. Retail Medicine Clinic (CVS Minute Clinic, Walgreens Healthcare Clinic, Clinic at Wal-Mart)
- n. Substance Abuse Treatment Facility (Inpatient)
- o. Urgent Care Facility
- p. Other
- q. Not Applicable

26. Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana). Please check all that apply.

CHECKBOXES

- a. Administer immunizations
- b. Drug evaluation, drug utilization review, and drug regimen review.
- c. Drug or drug-related research
- d. Obtain/maintain patient drug histories and other pharmacy records
- e. Prescribe permitted devices or supplies (Ex: Inhalation spacer, Nebulize, Supplies for medical devices, Normal saline and sterile water for irrigation for wound care, Diabetes blood sugar testing supplies, Pen needles, Syringes for medication use)
- f. Selection, storage, and distribution of drugs, dietary supplements, and devices.
- g. Supervise pharmacy interns, pharmacy technicians, or pharmacy technicians in training
- h. Supervise a licensed pharmacy technician employed at a remote dispensing facility
- i. Tobacco cessation services
- j. Utilize Prescription Drug Monitoring Program (PDMP – INSPECT in Indiana)

27. Please indicate the population groups to which you provide services:

- Newborns
- Children (ages 2-10)
- Adolescents (ages 11-19)
- Adults
- Geriatrics (ages 65+)
- Pregnant women

- Inmates
- Disabled individuals
- Individuals in recovery

28. Do you use telepharmacy to deliver services (telepharmacy as defined in IC 25-26-13.5-4; the provision of patient care by a pharmacy and pharmacist through the use of telecommunications or other technology to a patient in Indiana; it does NOT include patient care through the use of telecommunications by a pharmacy or pharmacist that is located in a hospital, an ambulatory outpatient surgical center, or a health facility)

RADIO BUTTONS

- a. Yes
- b. No