

Appendix A – Individual Respondent Characteristics

Diagnostic Safety Capacity Building – Calibration Resource

Form Approved
OMB No. xxxx-xxxx
Exp. Date xx/xx/20

Please complete the following information about yourself. This document is completed at the time of recruitment/interview and will take approximately 15 minutes to complete. Participation in the survey is voluntary.

Individual Respondent Characteristics Survey

Characteristic	Response Option*
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Race	Check all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander
Ethnicity	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Age in years	
Professional Background	<input type="checkbox"/> Physician (MD/DO) <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner
Specialty and/or board certification(s)	
Number of years in practice (since licensure)	
Location	City, State: _____
Practice Setting(s)	<input type="checkbox"/> Office-based practice <ul style="list-style-type: none"> <input type="checkbox"/> Primary Care <input type="checkbox"/> Specialty Care <input type="checkbox"/> FQHC <input type="checkbox"/> Multispecialty <input type="checkbox"/> Urgent Care Center <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____
Organization type	<input type="checkbox"/> Academic medical center <input type="checkbox"/> Other not-for-profit <input type="checkbox"/> For-profit
Do you hold an academic appointment or affiliation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you involved in	<input type="checkbox"/> Yes

training learners in your discipline (e.g., medical students, interns, residents, and/or fellows)?

No

*Each characteristic must include an option for did not respond/did not provide an answer

This survey is authorized under 42 U.S.C. 299a. The confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average 15 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857.