

Appendix D – Survey Questionnaire



NATIONAL NURSING WORKFORCE SURVEY

Marking Instructions

Use a No. 2 pencil or blue or black ink pen only.
Do not use pens with ink that soaks through the paper.
Make solid marks that fill the oval completely.

Make no stray marks on this form.
Do not tear or mutilate this form.



Demographics

1. What is your gender? Male Female

2. What is your race/ethnicity? (Mark all that apply)

- American Indian or Alaska Native
- Asian
- Black/African American
- Native Hawaiian or Other Pacific Islander
- White/Caucasian
- Hispanic/Latino
- Other

3. In what year were you born?

YEAR	
1	9
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

4. What type of nursing degree/credential qualified you for your first US nursing license?

- Vocational/practical certificate-nursing
- Diploma-nursing
- Associate degree-nursing
- Baccalaureate degree-nursing
- Master's degree-nursing
- Doctoral degree-nursing (DNP)
- Doctoral degree-nursing (PhD)
- Doctoral degree-nursing other

5. What is your highest level of education?

- Vocational/practical certificate-nursing
- Diploma-nursing
- Associate degree-nursing
- Associate degree-other field
- Baccalaureate degree-nursing
- Baccalaureate degree-other field
- Master's degree-nursing
- Master's degree-other field
- Doctoral degree-nursing practice (DNP)
- Doctoral degree-nursing (PhD)
- Doctoral degree-nursing other
- Doctoral degree-other field



License/Certification Information

6. What type of license do you currently hold? (Mark all that apply)

- RN LPN/VN Advanced Practice RN license

8. What year did you obtain your initial US licensure?

YEAR			
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

7. Indicate whether you are credentialed in your state to practice as any of the following:

- Nurse Practitioner Certified Registered Nurse Anesthetist Not licensed/certified as any of the above
 Clinical Nurse Specialist Certified Nurse Midwife

9. In what country did you receive your entry-level education?

- United States Philipines Other, please specify _____
 Canada India

10. In what country were you initially licensed as RN or LPN?

- United States Philipines Other, please specify _____
 Canada India

11. Please indicate the states in which you hold an active license to practice as an RN or LPN/VN:

- | | | | |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> AK | <input type="checkbox"/> IL | <input type="checkbox"/> ND | <input type="checkbox"/> TN |
| <input type="checkbox"/> AL | <input type="checkbox"/> IN | <input type="checkbox"/> NE | <input type="checkbox"/> TX |
| <input type="checkbox"/> AR | <input type="checkbox"/> KS | <input type="checkbox"/> NH | <input type="checkbox"/> UT |
| <input type="checkbox"/> AZ | <input type="checkbox"/> KY | <input type="checkbox"/> NJ | <input type="checkbox"/> VA |
| <input type="checkbox"/> CA | <input type="checkbox"/> LA | <input type="checkbox"/> NM | <input type="checkbox"/> VT |
| <input type="checkbox"/> CO | <input type="checkbox"/> MA | <input type="checkbox"/> NV | <input type="checkbox"/> WA |
| <input type="checkbox"/> CT | <input type="checkbox"/> MD | <input type="checkbox"/> NY | <input type="checkbox"/> WI |
| <input type="checkbox"/> DC | <input type="checkbox"/> ME | <input type="checkbox"/> OH | <input type="checkbox"/> WV |
| <input type="checkbox"/> DE | <input type="checkbox"/> MI | <input type="checkbox"/> OK | <input type="checkbox"/> WY |
| <input type="checkbox"/> FL | <input type="checkbox"/> MN | <input type="checkbox"/> OR | <input type="checkbox"/> AS |
| <input type="checkbox"/> GA | <input type="checkbox"/> MO | <input type="checkbox"/> PA | <input type="checkbox"/> GU |
| <input type="checkbox"/> HI | <input type="checkbox"/> MS | <input type="checkbox"/> RI | <input type="checkbox"/> MP |
| <input type="checkbox"/> IA | <input type="checkbox"/> MT | <input type="checkbox"/> SC | <input type="checkbox"/> VI |
| <input type="checkbox"/> ID | <input type="checkbox"/> NC | <input type="checkbox"/> SD | |

12. Please indicate the states in which you are currently practicing as an RN or LPN/VN:

- | | | | |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> AK | <input type="checkbox"/> IL | <input type="checkbox"/> ND | <input type="checkbox"/> TN |
| <input type="checkbox"/> AL | <input type="checkbox"/> IN | <input type="checkbox"/> NE | <input type="checkbox"/> TX |
| <input type="checkbox"/> AR | <input type="checkbox"/> KS | <input type="checkbox"/> NH | <input type="checkbox"/> UT |
| <input type="checkbox"/> AZ | <input type="checkbox"/> KY | <input type="checkbox"/> NJ | <input type="checkbox"/> VA |
| <input type="checkbox"/> CA | <input type="checkbox"/> LA | <input type="checkbox"/> NM | <input type="checkbox"/> VT |
| <input type="checkbox"/> CO | <input type="checkbox"/> MA | <input type="checkbox"/> NV | <input type="checkbox"/> WA |
| <input type="checkbox"/> CT | <input type="checkbox"/> MD | <input type="checkbox"/> NY | <input type="checkbox"/> WI |
| <input type="checkbox"/> DC | <input type="checkbox"/> ME | <input type="checkbox"/> OH | <input type="checkbox"/> WV |
| <input type="checkbox"/> DE | <input type="checkbox"/> MI | <input type="checkbox"/> OK | <input type="checkbox"/> WY |
| <input type="checkbox"/> FL | <input type="checkbox"/> MN | <input type="checkbox"/> OR | <input type="checkbox"/> AS |
| <input type="checkbox"/> GA | <input type="checkbox"/> MO | <input type="checkbox"/> PA | <input type="checkbox"/> GU |
| <input type="checkbox"/> HI | <input type="checkbox"/> MS | <input type="checkbox"/> RI | <input type="checkbox"/> MP |
| <input type="checkbox"/> IA | <input type="checkbox"/> MT | <input type="checkbox"/> SC | <input type="checkbox"/> VI |
| <input type="checkbox"/> ID | <input type="checkbox"/> NC | <input type="checkbox"/> SD | |

Employment Information

13. What is your employment status? (Mark all that apply)

- Actively employed in nursing full-time
 Actively employed in nursing part-time
 Actively employed in nursing per diem
 Actively employed in a field other than nursing full-time
 Actively employed in a field other than nursing part-time
 Actively employed in a field other than nursing per diem
 Working in nursing only as a volunteer
 Unemployed, seeking work as a nurse
 Unemployed, not seeking work as a nurse
 Retired

Primary position: The position at which you work the most hours during your regular work year.

Secondary position: The position at which you work the second greatest number of hours during your regular work year.

Per diem: an arrangement wherein a nurse is employed directly on an as needed basis and usually has no benefits.

14. If unemployed, please indicate the reasons:

- Taking care of home and family School
 Disabled Difficulty in finding a nursing position
 Inadequate Salary Other, please specify _____

Please answer questions 15 – 31 only if you are actively employed in nursing, if you are not actively employed in nursing you have completed the survey.

15. In how many positions are you currently employed as a nurse? 1 2 3 or more

16. How many hours do you work during a typical week in all your nursing positions?

HOURS		
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

17. Please indicate if you work in any of these areas or specialty settings:

- a. Camp Nurse Yes No
- b. Correctional Yes No
- c. Developmental Disability Yes No
- d. Faith-based (ex: Parish Nurse) Yes No
- e. Forensic Yes No
- f. Holistic Yes No
- g. Military/uniform Services Yes No
- h. Telehealth Yes No
- i. Travel Nurse Yes No

18. Please indicate the state and zip code of your primary employer:

- AK IL ND TN
- AL IN NE TX
- AR KS NH UT
- AZ KY NJ VA
- CA LA NM VT
- CO MA NV WA
- CT MD NY WI
- DC ME OH WV
- DE MI OK WY
- FL MN OR **AS**
- GA MO PA **GU**
- HI MS RI **MP**
- IA MT SC **VI**
- ID NC SD

ZIP CODE				
0	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9

19. Please estimate your 2014 pre-tax annual earnings from your primary nursing position. Include overtime and bonuses, but exclude sign-on bonuses.

						.00 per year
0	0	0	0	0	0	
1	1	1	1	1	1	
2	2	2	2	2	2	
3	3	3	3	3	3	
4	4	4	4	4	4	
5	5	5	5	5	5	
6	6	6	6	6	6	
7	7	7	7	7	7	
8	8	8	8	8	8	
9	9	9	9	9	9	

20. Please identify the type of setting that most closely corresponds to your primary nursing practice position:

- Academic Setting Home Health Policy/Planning/Regulatory/Licensing Agency
- Ambulatory Care Setting Hospital Public Health
- Assisted Living Facility Insurance Claims/Benefits School Health Service
- Community Health Nursing Home/Extended Care Other
- Correctional Facility Occupational Health

21. Please identify the position title that most closely corresponds to your primary nursing practice position:

- Advanced Practice Nurse Consultant Nurse Manager Other-Not Health Related
- Case Manager Nurse Executive Nurse Researcher Staff Nurse
- Clinical Nurse Leader Nurse Faculty Other-Health Related

22. Please identify the employment specialty that most closely corresponds to your primary nursing practice position:

- Acute Care/Critical Care Medical Surgical Primary Care
- Adult Health/Family Health Neonatal Psychiatric/Mental Health/Substance Abuse
- Anesthesia Nephrology Public Health
- Community Neurology/Neurosurgical Radiology
- Emergency/Trauma Occupational Health Rehabilitation
- Genetics Oncology School Health
- Geriatric/Gerontology Orthopedic Urologic
- Home Health Palliative Care/Hospice Women's Health
- Informatics Pediatrics Other
- Maternal-Child Health Perioperative

