We recognize the importance of assessing Florida’s current and future physician workforce. Section 381.4018, Florida Statutes requires that the Department of Health evaluate the geographic distribution and specialty mix of active Florida Physicians through this survey. Your responses will be instrumental in shaping Florida’s healthcare policies. Your time and effort in completing the questions below is appreciated.

License Number ____________________    Name ______________________________
D.O. ___    M.D. _____ (Please check one)

1. Do you practice medicine at any time during the year in Florida?
   O Yes. If yes, please proceed to question 2.
   O No. If No,
   1a. The main reason you have a Florida license, but don’t practice medicine is (choose only one)
       O Retired
       O Malpractice Insurance Rates
       O Liability Exposure
       O Medicare/Medicaid Reimbursement Rates
       O Private Health Plan Reimbursement Rates
       O Planning to move to Florida
       O Do not maintain a full-time residence in Florida
       O Other

   1b. Do you plan to relocate to Florida?
       O In 1-2 years
       O In 3-4 years
       O Do not plan to relocate

   1c. My specialty is: _________________________________________
       (Please use drop down menu of specialty choices)

If you DO NOT practice medicine or otherwise work as a physician in Florida, you are now finished with the survey. Thank you.
2. How many months did you practice in Florida in the last 12 months?
   - O 1-2 months
   - O 3-4 months
   - O 5-6 months
   - O 7-8 months
   - O 9-10 months
   - O 11-12 months

3. List your primary specialty of your current clinical practice and its total hours per week.

<table>
<thead>
<tr>
<th>Numeric Code</th>
<th>Specialty Area (Please use specialty list provided)</th>
<th>0-10 Hrs Per Week</th>
<th>11-20 Hrs Per Week</th>
<th>21-29 Hrs Per Week</th>
<th>30-39 Hrs Per Week</th>
<th>40-49 Hrs Per Week</th>
<th>50 or More Hrs Per Week</th>
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</table>

4. List any other specialty of your current clinical practice and total hours associated with each specialty per week.

<table>
<thead>
<tr>
<th>Numeric Code</th>
<th>Specialty Area (Please use specialty list provided)</th>
<th>0-10 Hrs Per Week</th>
<th>11-20 Hrs Per Week</th>
<th>21-29 Hrs Per Week</th>
<th>30-39 Hrs Per Week</th>
<th>40-49 Hrs Per Week</th>
<th>50 or More Hrs Per Week</th>
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</tbody>
</table>

5. Please list your primary work location by county (Please use county list provided).

<table>
<thead>
<tr>
<th>Numeric Code</th>
<th>County Name</th>
<th>0-10 Hrs Per Week</th>
<th>11-20 Hrs Per Week</th>
<th>21-29 Hrs Per Week</th>
<th>30-39 Hrs Per Week</th>
<th>40-49 Hrs Per Week</th>
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</table>

6. Please list any other work locations by county (Please use county list provided).

<table>
<thead>
<tr>
<th>Numeric Code</th>
<th>County Name</th>
<th>0-10 Hrs Per Week</th>
<th>11-20 Hrs Per Week</th>
<th>21-29 Hrs Per Week</th>
<th>30-39 Hrs Per Week</th>
<th>40-49 Hrs Per Week</th>
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</tbody>
</table>
7. Of your total hours worked in a week, how many hours do you spend on:

<table>
<thead>
<tr>
<th>a. Patient care (office and hospital)</th>
<th>b. Administrative Matters</th>
<th>c. Research and Teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>O 0-5</td>
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<td>O 55-60</td>
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<tr>
<td>O 61 or more</td>
<td>O 61 or more</td>
<td>O 61 or more</td>
</tr>
</tbody>
</table>

8. How many patients on average do you see per week (office and hospital)?

| O 0-25                              | O 126-150                 |
| O 26-50                             | O 151-175                 |
| O 51-75                             | O 176-200                 |
| O 76-100                            | O 201 or more             |
| O 101-125                           |                           |

9. Which setting best describes where the majority of your practice occurs? (Choose only one)

- O Office Practice-Solo Practice
- O Office Practice-Group Practice – Single specialty
- O Office Practice-Group Practice – Multi-specialty
- O Hospital – Hospital Based Physician (Non-Emergency)
- O Hospital – Other
- O Hospital – Hospitalist
- O Hospital – Outpatient Dept
- O Hospital Emergency Room
- O County Health Department
- O Urgent Care Center
- O Nursing Home/Extended Care Facility
- O Volunteer Free Clinic
- O Federally Qualified Health Center
- O Ambulatory Surgery Center
- O Other

10. If you are an employed physician, is your employer:

- O Medical School or Parent University
- O Government Agency
- O Staff or Group HMO
- O Other

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Rule Number 64B-9.002
11. Are you currently enrolled in an internship, residency, or fellowship program?
   O Yes _____________________(Specialty) _________(Year-PGY1, 2, 3, 4, 5, 6, or 7)
   O No

12. What was your total debt at the time of graduation from medical school?
   O No Debt
   O Less than $25,000
   O More than $25,000, but less than $50,000
   O More than $50,000, but less than $75,000
   O More than $75,000, but less than $100,000
   O More than $100,000, but less than $125,000
   O More than $125,000, but less than $150,000
   O $150,000 or more

If you are CURRENTLY enrolled in an internship, residency or fellowship program,
please stop here. Thank you for your time in completing this survey.

13. Do you have hospital privileges?
   O Yes
   O No

13a. If yes, at how many individual hospitals do you have hospital privileges?
   O 1
   O 2
   O 3
   O 4 or more

13b. If no, is the decision to not have hospital privileges voluntary?
   O Yes
   O No

14. Do you provide on-call emergency room coverage (NOT Emergency Department Physician)?
   O Yes
   O No

14 a. The main reason I do not provide on-call coverage is (choose only one):
   O Exempt by hospital by-laws
   O Emergency Department Physician
   O Retired
   O Lifestyle Considerations
   O Malpractice Insurance
   O Liability Exposure
   O Compensation
   O Other

Thank you, please move to question 15.
If yes:
14 b. At how many individual hospitals do you provide on-call emergency room coverage?
   O 1
   O 2
   O 3
   O 4 or more
14 c. How many total days per month do you take emergency call?
   O 1-2
   O 3-4
   O 5-6
   O 7-8
   O 9-10
   O 11 or more
14 d. During the past 2 years, has the number of emergency on-call days
   O Increased
   O Decreased
   O Stayed the same
14 e. If you are decreasing your on-call days, what is the main reason?
   O Retiring
   O Lifestyle Considerations
   O Liability Exposure
   O Private Health Plan Reimbursement Rates
   O Medicare/Medicaid Reimbursement Rates
   O Compensation
   O Malpractice Insurance Rates
   O Work in an Urgent Care Clinic
   O Other

15. Do you take trauma call, or attend to trauma patients, at a verified trauma center?
   O Yes
      a. If yes, which type?
         O Level I
         O Level II
         O Pediatric
         O More than one of the above
   O No.

16. Are you currently accepting new Medicare patients in your practice?
   O Yes
   O No
   16a. If no, what is the main reason you are not accepting new Medicare patients?
       O Low Compensation
       O Billing Requirements
       O Too Much Paperwork
       O Practice is at full capacity
       O Concerned about Fraud Issues

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Rule Number 64B-9.002
License Number ____________________
17. Are you currently accepting new Medicaid patients in your practice?
   O Yes
   O No

17 a. If no, what is the main reason you are not accepting new Medicaid patients?
   O Low Compensation
   O Billing Requirements
   O Too Much Paperwork
   O Practice is at full capacity
   O Concerned about Fraud Issues

18. Do you plan to retire in the next 5 years?
   O No
   O Yes

18 a. If yes, the main reason for retiring (Check only one):
   O Time to retire
   O Compensation
   O Family
   O Liability Exposure
   O Private Health Plan Reimbursement Rates
   O Medicare/Medicaid Reimbursement Rates
   O Malpractice Insurance Rates
   O Other

18 b. If yes, do you plan to have a limited license for volunteering?
   O yes
   O no

19. Do you plan to move to work in another state in the next 5 years?
   O No
   O Yes ____________________________ (Drop Down State or Out of Country)

19 a. If yes, the main reason for moving to work in another state:
   O Family
   O Compensation
   O Liability Exposure
   O Malpractice Insurance Rates
   O Medicare/Medicaid Reimbursement Rates
   O Private Health Plan Reimbursement Rates
   O Looking for a change
   O Education / training in another state
   O Other
20. Do you plan to change your specialty in the next 5 years?
   O Yes ________________________ (Drop Down Specialty List for Your New Specialty )
   O No

20a. If yes, the main reason for changing your specialty:
   O Family
   O Malpractice Insurance Rates
   O Liability Exposure
   O Medicare/Medicaid Reimbursement Rates
   O Private Health Plan Reimbursement Rates
   O Compensation
   O Education / training in another state
   O Potential for Higher Compensation
   O Other

Please review the following list of specialties and answer the questions associated with what you have indicated to be your primary specialty (question 3) and any additional specialty (question 4) of your current clinical practice. If you have indicated a specialty without associated questions, please stop here. Thank you for completing the survey.

Thank you for completing the survey.
GENERAL INTERNAL MEDICINE

Did you do a post-residency fellowship?
  O No
  O Yes, in which state? __________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O Internal Medicine                          O Pediatrics Care
O Geriatrics                                        O In-Hospital Care
O Women’s’ Health                                 O Your sub-specialty
O All of the Above

ALLERGY / IMMUNOLOGY

Did you do a post-residency Allergy/Immunology fellowship?
  O No
  O Yes   In which state? _________(Please use state menu)

Check the circles if you will see a particular category of patient
O Internal Medicine            O Allergic Skin Disease
O Adult Asthma                                O Immune Deficiency
O Childhood Asthma                        O Food/Insect/Drug Allergy
O Allergic Rhinitis              O All of the Above

CARDIOVASCULAR DISEASE

Did you do a post-residency Cardiology fellowship?
  O No
  O Yes   In which state? _________________ (Please use state menu)

Did you do a Cardiology Sub-specialty fellowship?
  O No
  O Yes, In which area (please check only one)
    O General Clinical Cardiologist
    O Interventional Cardiologist
    O Echocardiologist (Echocardiographer)
    O Electrophysiologist
    O Nuclear Cardiologist
    O MR/CT Cardiologist
    O Heart Failure & Transplant Cardiologist
    O Preventive Cardiologist
    O Vascular Medicine Specialist
    O Cardiovascular Investigator
    O Other
PHYSICIAN WORKFORCE SURVEY

If yes, in which state? __________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O Internal Medicine               O Heart Failure & Transplant
O General Cardiology              O Nuclear Cardiologist
O Interventional Cardiology       O Pediatric Cardiology
O ECHO                             O Vascular Medicine
O Electrophysiology               O MR/CT Cardiologist
O All of the Above

ENDOCRINOLOGY

Did you do a post-residency Endocrinology fellowship?

O No
O Yes   In which state? __________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O Internal Medicine               O Thyroid Disease
O Adult Endocrinology             O Pediatric Endocrinology
O Diabetes Mellitus               O All of the Above

GASTROENTEROLOGY

Did you do a post-residency Gastroenterology fellowship?

O No
O Yes   In which state? ___________ (Please use state menu)

Check the circles if you will see a particular category of patient
O Internal Medicine               O Hepatology
O Gastroenterology                O Pediatrics
O ERCP                             O Endoscopic Ultrasound
O All of the Above

GENETICS

Did you do a post-residency Genetics fellowship?

O No
O Yes   In which (Please choose one)
O Clinical Genetics
O Biochemical Genetics
O Molecular Genetics
O Cytogenetics
O Other

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License Number _________________________
Rule Number 64B-9.002
PHYSICIAN WORKFORCE SURVEY

If yes, in which state? __________________ (Please use state menu)

Check the circles if you will see a particular category of patient

O Prenatal Genetics  O Chromosome Disorders
O Adult Genetics    O Neuromuscular Disorders
O Cancer Genetics   O Developmental Delay/Autism
O Biochemical Genetics  O Dysmorphology
O Molecular Genetics (190)  O Cytogenetics
O Internal Medicine  O Pediatrics
O All of the Above

===============================================

GERIATRICS

Did you do a post-residency Geriatrics fellowship?

O No
O Yes    In which state? __________________________ (Please use state menu)

Check the circles if you will see a particular category of patient

O Internal Medicine  O Family Medicine
O Geriatric consultation  O Nursing home care
O Geriatric primary care  O All of the Above

==============================================================

HEMATOLOGY

Did you do a post-residency Hematology fellowship?

O No
O Yes    In which state? __________________________ (Please use state menu)

Check the circles if you will see a particular category of patient

O Internal Medicine  O Hemophilia diseases
O Oncology  O Hematology
O All of the Above

==============================================================

ONCOLOGY

Did you do a post-residency Oncology fellowship?

O No
O Yes    In which state? __________________________ (Please use state menu)

Check the circles if you will see a particular category of patient

O Internal Medicine  O Hemophilia diseases
O Hematology  O Oncology
O All of the Above

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Rule Number 64B-9.002
HEMATOLOGY & ONCOLOGY

Did you do a post-residency fellowship in Hematology & Oncology?
- O No
- O Yes  In which state? ______________________ (Please use state menu)

Check the circles if you will see a particular category of patient
- O Oncology
- O Hemophilia diseases
- O Hematology
- O All of the Above

INFECTIOUS DISEASE

Did you do a post-residency Infectious Disease fellowship?
- O No
- O Yes  In which state? __________________________(Please use state menu)

Check the circles if you will see a particular category of patient
- O Internal Medicine
- O Adult Infectious Diseases
- O HIV/AIDS
- O All of the Above

NEPHROLOGY

Did you do a post-residency Nephrology fellowship?
- O No
- O Yes , In (Please choose one)
  - O Adult Nephrology
  - O Pediatric Nephrology
  - O Renal Transplantation
  - O ICU Nephrology
  - O Interventional Nephrology
  - O Dialysis Patient Care

In which state?________________________ (Please use state menu)

Check the circles if you will see a particular category of patient
- O Internal Medicine
- O Renal Transplantation
- O ICU Nephrology
- O Interventional Nephrology
- O Dialysis Patient Care
- O Pediatric Nephrology
- O Dialysis Unit Administration
- O Adult Nephrology
- O All of the Above
PHYSICIAN WORKFORCE SURVEY

PULMONARY DISEASE
Did you do a post-residency Pulmonary fellowship?
  O No
  O Yes   In which state? ____________________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O Internal Medicine     O Critical Care / ICU
O Sleep Medicine       O Pulmonary outpatient
O All of the Above

CRITICAL CARE MEDICINE
Did you do a post-residency Critical Care fellowship?
  O No
  O Yes   In which state? ____________________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O ICU                                     O Your primary specialty
O Burn unit                               O Trauma unit
O All of the Above

RHEUMATOLOGY
Did you do a post-residency Rheumatology fellowship?
  O No
  O Yes   In which state? ____________________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O Internal Medicine     O Clinical Research
O Pediatric Rheumatology   O Adult Rheumatology
O All of the Above

SPORTS MEDICINE
Did you do a post-residency Sports Medicine fellowship?
  O No
  O Yes   In which state? ____________________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O Internal Medicine     O Sports Medicine
O Family Medicine       O All of the Above

SLEEP MEDICINE
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Rule Number 64B-9.002
PHYSICIAN WORKFORCE SURVEY

Did you do a post-residency fellowship in Sleep Medicine?
  O No
  O Yes In which state? _____________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O Internal Medicine O Pulmonary Medicine
O Sleep Medicine O Neurology
O All of the Above

FAMILY MEDICINE

Did you do a post-residency fellowship?
  O No
  O Yes, In:
    O Sports Medicine
    O Pediatrics
    O Geriatrics
    O Other

In which state? _____________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O Office (Outpatient) Care only; No Hospital O Geriatrics
O Office and Hospital care O Sports Medicine
O Adolescent Medicine >12y/o O HIV Primary Care
O Pediatrics 2 to 12y/o O Immunizations
O Infants care < 2y/o O Colonoscopy
O Delivery O Sigmoidoscopy
O Prenatal services O Stress testing
O Cosmetic (Laser procedures, Botox, etc.) O Auto Injury (PIP)
O All of the Above

DERMATOLOGY

Did you do a post-residency fellowship?
  O No
  O Yes, In:
    O Dermpath
    O Cosmetic, Mohs Surgery
    O Contact Dermatitis
    O Pediatric Dermatology
    O Other

DH MQA 1119, 08/09 License Number _____________________
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PHYSICIAN WORKFORCE SURVEY

In which state? __________________(Please use state menu)

Check the circles if you will see a particular category of patient

O General Dermatology
O Skin Cancer Surgery
O Moh's Surgery
O All of the Above

Do you see inpatient Hospital Consults?
   O Yes
   O No

NEUROLOGY

Did you do a post-residency fellowship?
   O No
   O Yes, In which area:
       O Electrophysiology
       O Rehabilitation
       O EEG
       O Stroke
       O Sleep
       O Other

In which state? __________________ (Please use state menu)

Check the circles if you will see a particular category of patient

O Adult Neurology
O Pediatric Neurology
O Hospital based neurology (no office)
O Primarily office-based/some hospital
O Primarily hospital-based/some office
O Sleep medicine
O All of the Above

PHYSICAL MEDICINE

Did you do a post residency fellowship?
   O No
   O Yes  In which area:
       O Pain Medicine
       O Spinal Cord Medicine
       O Hospice & Palliative Medicine
       O Neuromuscular Medicine
       O Pediatric Rehabilitation
       O Sports Medicine
       O Other

In which state? __________________(Please use state menu)
Check the circles if you will see a particular category of patient
- Adult Rehabilitation
- Pediatric Rehabilitation
- Electrodiagnosis
- Sports Medicine
- Pain Medicine
- Research
- Teaching
- Other
- All of the Above

PSYCHIATRY

Did you do a post-residency fellowship?
- No
- Yes, in which area:
  - Geriatrics
  - Addictions
  - Forensics
  - Child and Adolescents
  - Other

In which state? ______________________ (Please use state menu)

Do you admit, consult or treat patients at a hospital?
- No
- Yes

Do you admit, consult or treat patients at a residential treatment program?
- No
- Yes

Check the circles if you will see a particular category of patient
- Geriatrics
- Forensics
- Addictions
- Children
- All of the Above

PAIN MEDICINE

Did you do a post-residency fellowship in Pain Medicine?
- No
- Yes, in which state? ______________________ (Please use state menu)

Check the circles if you will see a particular category of patient
- Interventional treatment
- Medical management
- Legal work / review cases
- Auto cases
- Hospital consults
- Primary specialty
- All of the Above

DH MQA 1119, 08/09
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PHYSICIAN WORKFORCE SURVEY

GENERAL SURGERY

Did you do a post-residency fellowship?
O No
O Yes, In which area:
   O Vascular
   O Pediatric
   O Hand
   O Colon & Rectal
   O Critical Care
   O Other

In which state? _________________(Pleas use the state menu)

Check the circles if you will see a particular category of patient
O Trauma
O Breast cancer
O Gynecologic Surgery
O Colon & Rectal Surgery
O All of the Above

CARDIAC / THORACIC SURGERY

Are you board certified in Cardiothoracic Surgery?
O No
O Yes ______ (enter 4-digit year)

Did you do a post-residency fellowship?
O No
O Yes , In which area?
   O Pediatrics
   O Transplantation
   O Other

In which state? _________________(Please use state menu)

Check the circles if you will see a particular category of patient
O Adult hearts
O Pediatric hearts
O Transplantation
O All of the Above
PHYSICIAN WORKFORCE SURVEY

COLON & RECTAL SURGERY

Did you do a post-residency fellowship in Colon & Rectal Surgery?
   O No
   O Yes    In which state? _____________ (Please use state menu)

Check the circles if you will see a particular category of patient
   O Anal & perianal disease
   O Inflammatory bowel disease
   O Colon and rectal cancer
   O Constipation and motility disorders
   O All of the above

HAND SURGERY

Did you do a post-residency fellowship in Hand Surgery?
   O No
   O Yes    In which state? _____________ (Please use state menu)

Check the circles if you will see a particular category of patient
   O Trauma
   O Reconstructive
   O Microvascular
   O All of the above

Do you take call for replantation surgery?   O Yes   O No

NEUROLOGICAL SURGERY

Did you do a post-residency fellowship?
   O No
   O Yes, In which area:
       O Spine
       O Cerebrovascular
       O Pediatric
       O Tumor
       O Functional
       O Other

   In which state? ________________ (Please use state menu)
Check the circles if you will see a particular category of patient
O General Neurosurgery  O Spinal Surgery
O Trauma  O Peripheral Nerve
O Brain Tumor  O Pain / Functional
O Cerebrovascular  O Radiosurgery
O Pediatric Neurosurgery  O Endovascular
O All of the above

OPHTHALMOLOGY

Did you do a post-residency fellowship?
O No
O Yes  In which area?
   O Retina
   O Cataract
   O Cornea
   O Glaucoma
   O Pediatric
   O Plastic
   O Other

Check the circles if you will see a particular category of patient
O General Ophthalmology  O Pediatrics-Strabismus
O Cornea- External Diseases  O Neuro-Ophthalmology
O Retinal Diseases  O Ophthalmic Plastic Surgery
O Glaucoma  O All of the above

ORTHOPEDIC SURGERY

Did you do a post-residency fellowship?
O No
O Yes, In which area?
   O Reconstructive  O Oncology
   O Sports  O Spine
   O Trauma  O Ankle/Foot
   O Pediatrics  O Shoulder/Elbow
   O Hand  O Other

In which state? ____________________________ (Please use state menu, page 35)
PHYSICIAN WORKFORCE SURVEY

Check the circles if you will see a particular category of patient
O General Orthopedics O Hand
O Adult reconstruction O Shoulder/elbow
O Sports Medicine O Ankle/foot
O Trauma O Oncology
O Pediatrics O Spine
O All of the above

OTOLARYNGOLOGY

Did you do a post-residency fellowship?
   O No
   O Yes, in which area?
       O Pediatrics
       O Plastic
       O Cancer
       O Otology
       O Oncology
       O Other

In which state? _________________________ (Please use state menu)

Check the circles if you will see a particular category of patient
O General Otolaryngology O General Otology
O Pediatric Otolaryngology O Rhinology
O Otology, Neurotology, Skull Base surgery O Laryngology/Voice
O Head and Neck Cancer Surgery O Facial Plastics
O All of the above

If you take ER call, do you take:
   ER Call for General Otolaryngology O Yes O No
   ER Call for Pediatric Otolaryngology O Yes O No
   ER Call for Maxillofacial trauma O Yes O No

PEDIATRIC SURGERY

Did you do a post-residency fellowship in Pediatric Surgery?
   O No
   O Yes    In which state? _________________(Please use state menu)
Check the circles if you will see a particular category of patient

O Neonatal (age 0-30 days, or admitted to NICU, regardless of age)
O Infants (age 0-1 year)
O Toddlers (age 1-5 years)            O Adolescents (age >12 years)
O Children (age 6-12 years)                             O Adult General Surgery
O All of the above

PLASTIC SURGERY

Are you board certified in Plastic Surgery?
   O No
   O Yes ______ (enter 4-digit year)

Did you do a post-residency fellowship?
   O No
   O Yes, in which area?
       O Pediatric
       O Craniofacial
       O Aesthetic
       O Hand
       O Burns

In which state? ____________________(Please use state menu)

Check the circles if you will see a particular category of patient
O Trauma/burns          O Maxillofacial
O Hand/Microsurgery    O Aesthetic/Breast
O Reconstructive       O Pediatric/Craniofacial
O All of the above

If you take ER call, do you take call for
   Hand Surgery              O Yes   O No
   Maxillofacial trauma      O Yes   O No
   General Plastic Surgery  O Yes   O No

DH MQA 1119, 08/09
License Number ____________________
Rule Number 64B-9.002
UROLOGY

Did you do a post-residency fellowship?
  O No
  O Yes, in which area?
    O pediatrics
    O oncology

In which state? _____________________ (Please use state menu)

Check the circles if you will see a particular category of patient
  O Adult Urology patients   O Pediatric Urology patients

Check any of the procedures you will perform:
  O radical cystectomy    O radical prostatectomy
  O robotic surgery    O penile prosthesis
  O male incontinence surgery
  O female incontinence/pelvic floor reconstruction surgery
  O All of the above

Do you use physician extenders?
  O No
  O Yes

Are you employed by a hospital?
  O No
  O Yes

Do you accept Medicaid?
  O No
  O Yes

VASCULAR SURGERY

Did you do a post-residency fellowship in Vascular Surgery?
  O No
  O Yes    In which state?____________________ (Please use state menu)
Check the circles if you will see a particular category of patient

O General Surgery  O Aorta endografts
O Mesenteric bypass  O Renal artery stents
O Carotid stents  O Peripheral angiograms
O All of the above

OB-GYN

Do you deliver babies?
  O No
  O Yes

How many routine deliveries do you perform per month?
  O None
  O 1 - 10 per month
  O 11 – 20 per month
  O 21 – 30 per month
  O 31 or more per month

How many high risk deliveries do you perform per month?
  O None
  O 1 - 10 per month
  O 11 – 20 per month
  O 21 – 30 per month
  O 31 or more per month

How many C-Sections do you perform per month?
  O None
  O 1 - 10 per month
  O 11 – 20 per month
  O 21 – 30 per month
  O 31 or more per month

How many emergency room deliveries do you perform per month for patients having minimal or no “known” prenatal care?
  O None
  O 1 - 10 per month
  O 11 – 20 per month
  O 21 – 30 per month
  O 31 or more per month

DH MQA 1119, 08/09  License Number_______________________
Rule Number 64B-9.002
How many assists or consultative services do you perform per month?
- None
- 1 - 10 per month
- 11 – 20 per month
- 21 – 30 per month
- 31 or more per month

Are you planning to discontinue doing obstetric care for any reason in the next two years?
- Yes
- No
  a. If yes, check all reasons that apply:
     - Retired
     - Cost of Professional Insurance
     - Medical Malpractice Litigation
     - Liability Exposure
     - Government Reimbursement Rates
     - Private Health Plan Reimbursement Rates
     - Planning to move out-of-state
     - Do not maintain a full-time residence in Florida
     - Other

Are you protected by the NICA program?
- Yes
- No
  a. If no, what is the most important reason (pick only one)
     - Too costly
     - Inadequate protection
     - I don’t know anything about the program
     - Other
PEDIATRICS

Did you do a post-residency fellowship?

O No

O Yes, in which area?

O Adolescent

O Neonatal-perinatal medicine

O Pediatric critical care medicine

O Pediatric pulmonology

O Pediatric emergency medicine

O Pediatric nephrology

O Pediatric cardiology

O Pediatric rheumatology

O Pediatric endocrinology

O Pediatric gastroenterology

O Pediatric hematology/oncology

O Pediatric sports medicine

O Pediatric infectious diseases

O Other

O Developmental-Behavioral Pediatrics

In which state? _________________________ (Please use state menu)

Check the circles if you will see a particular category of patient

O Hospital Practice

O Office Practice

O Neonatology

O Public Health

O Pediatric Intensivist

O Medical School Teaching

O Pediatric Hospitalist

O Administrative Medicine

O Pediatric Emergency Care

O All of the above

Are you working full time?    O Yes    O No

If No, is this a personal choice?    O Yes    O No

Is this due to limited employment opportunity in your location?    O Yes    O No

-----------------------------------------------

RADIOLOGY

Are you board certified?

O No

O Yes    _____ (enter 4-digit year)

O Recertified?    _____ (enter 4-digit year)

Are you subspecialty certified?

O Yes    _____ (enter 4-digit year)

O No

Do you have CAQ (Certificate of Added Qualifications) Recertification?

O Yes    _____ (enter 4-digit year)

O No

DH MQA 1119, 08/09

License Number _________________________

Rule Number 64B-9.002
Do you see a particular category of patients? (Choose all that apply)

- [ ] Mammography
- [ ] GI Radiology
- [ ] Neuroradiology
- [ ] GU Radiology
- [ ] Pediatric Radiology
- [ ] All of the above

a. If you checked that mammography is part of your practice do you:

   - [ ] Read screening mammograms? Yes No
   - [ ] Read diagnostic mammograms and sonograms? Yes No
   - [ ] Read breast MRI’s Yes No
   - [ ] Read MRI guided core biopsies? Yes No
   - [ ] Perform ultrasound & stereotactic guided core biopsies? Yes No

b. If mammography is not part of your clinical practice, please choose the most important reason why not:

   - [ ] Family
   - [ ] Cost of Professional Insurance
   - [ ] Medical Malpractice Litigation
   - [ ] Liability Exposure
   - [ ] Government Reimbursement Rates
   - [ ] Private Health Plan Reimbursement Rates
   - [ ] Looking for a change
   - [ ] Education / training in another state
   - [ ] Potential for Higher Compensation
   - [ ] Other

Do you consider yourself a pediatric radiologist?

- [ ] No
- [ ] Yes

   a. If yes, do you practice (check all that apply):

      - [ ] Musculoskeletal
      - [ ] Neuroradiology
      - [ ] Nuclear Medicine
      - [ ] Interventional Radiology
      - [ ] General
Check your type of work location (check all that apply)

- Hospital
- Stand alone Imaging Center
- Hospital-based Imaging Center
- Off site (Internet-based) Radiology
- Multispecialty Group Imaging Center
- Other

Do you use an outside service (Teleradiology)?
- Yes
- No
  a. If yes, which services do you use (check all that apply):
     - Day coverage
     - Night coverage
     - In-state physicians
     - Out-of-state physicians
     - Subspecialty consultations
     - Out-of-country physicians
     - Other

Do you treat under-insured patients?
- Yes
- No

Do you treat uninsured patients?
- Yes
- No

Are you a radiation oncologist?
- Yes
- No. Please stop here. Thank you for your time and effort to complete this survey.
  a. If yes, are you certified by the American Board of Therapeutic Radiology?
     - Yes
     - No

RADIOLOGY ONCOLOGY

Are you board certified in Radiology?
- No
- Yes ______ (enter 4-digit year)
PHYSICIAN WORKFORCE SURVEY

Did you do a post-residency fellowship in Radiologic Oncology?
   O No
   O Yes In which state? _____________________ (Please use state menu)

Are you subspecialty certified?
   O No
   O Yes _____ (enter 4-digit year)

Check the circles if you will see a particular category of patient
   O Adult                              O HDR Implants
   O Pediatrics                         O IMRT
   O brachytherapy(LDR)                 O SRS/SRT (defined as 1-5 fractions, each fraction greater than or equal to 800cGY)
   O All of the above

ANESTHESIA

Did you do a post-residency fellowship?
   O No
   O Yes, in which area?
       O Cardiac
       O Pediatric
       O Critical Care
       O Trauma
       O Pain Management
       O Other

   In which state? _____________________ (Please use state menu)

Check the circles if you will see a particular category of patient
   O General Anesthesiology            O Trauma Anesthesiology
   O Obstetrical Anesthesiology        O Critical Care Medicine
   O Cardiac Anesthesiology            O Postoperative pain
   O Pediatric Anesthesiology          O Pain Medicine
   O All of the above
PATHOLOGY

Did you do a post-residency fellowship?
  O No
  O Yes, in which area?
    O Blood banking/transfusion medicine
    O Chemical pathology
    O Cytopathology
    O Forensic Pathology
    O Hematology medical Microbiology
    O Neuropathology
    O Pediatric Pathology
    O Selective Pathology
    O Dermatopathology
    O Molecular Genetic Pathology

In which state? ________________ (Please use state menu)

Check the circles if you will see a particular category of patient

O Chemical Pathology O Medical Microbiology
O Molecular Genetic Pathology O Cytopathology
O Neuropathology O Dermatopathology
O Forensic Pathology O Pediatric Pathology
O Hematology O Surgical Pathology
O Blood Banking/Transfusion Medicine O All of the above

EMERGENCY MEDICINE

Did you do a post-residency fellowship?
  O No
  O Yes, in which area?
    O EMS
    O Administration
    O Research
    O Toxicology
    O Pediatric
    O Trauma
    O Other

In which state? ________________ (Please use state menu)
Check the circles if you will see a particular category of patient
O  Adult Care  O  Trauma
O  OB / GYN   O  Psychiatric Care
O  Pediatrics  O  General Orthopedics
O  All of the above

Do you work in a Level I Trauma Center?
   O  Yes
   O  No

Do you work in a Level II Trauma Center?
   O  Yes
   O  No
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