U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Resources and Services Administration

2004 National Sample Survey of Registered Nurses

Conducted by
The Gallup Organization

The *2004 National Sample Survey of Registered Nurses* is being conducted for the Health Resources and Services Administration of the U.S. Department of Health and Human Services in compliance with Title VIII, Public Law 94-63, the Nurse Training Act of 1975, section 951; and Public Law 105-392, section 806(f), the Health Professions Education Partnerships Act of 1998; 42 USC 295k, section 792 of the U.S. Public Health Service Act. **Strict confidentiality of all information obtained from individuals surveyed in NSSRN is assured by current Federal laws and regulations.** 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. The OMB control number for this project is 0915-0276. Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching data sources, gathering or maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-45, Rockville, Maryland, 20857. The Gallup Organization will process all personal data you provide and will use such information for statistical and research purposes. By completing and returning this survey, you give your consent to process and transfer your personal data to the United States.

Please complete only one questionnaire and return any extra copies you receive, preferably in the same envelope (see Instructions on page 1).

Please correct any errors in the name/address information and States where you are actively licensed.

Corrections to First Name

Corrections to M.I.

Corrections to Last Name

Corrections to Number and Street

Corrections to City/Town

Corrections to State

Corrections to ZIP Code

Corrections to State(s) Where Actively Licensed (If there are any corrections to the list in the box to the right, please re-list ALL of the States where you are actively licensed.)

[First Name M.I. Last Name]
[Address 1]
[Address 2]
[City, State ZIP Code]

State(s) Where Actively Licensed:
[State 1, State 2, State 3]

Web Site URL: https://gx.gallup.com/nurse.gx

Access Code: [XXXXXX]

Quex # [X]

OMB No. 0915-0276
Expiration Date: 8/31/2005

Instructions

How do I complete the survey electronically?

On your Web browser, log onto https://gx.gallup.com/nurse.gx and type in your unique Access Code that is printed in the box in the lower right corner of the questionnaire cover page. If you complete the survey online, you do not need to return this paper questionnaire.

What if I received more than one questionnaire?

We may not have been able to eliminate all of the duplications in our list of nurses who have more than one license, so you may receive more than one questionnaire. **Please complete only one questionnaire but return any extra copies you receive, preferably in the same envelope as your completed survey. Please write "DUPLICATE" at the top of these blank surveys.** By returning extra surveys: we can avoid unnecessary follow-up mailings to you. (For those who receive duplicate questionnaires, if you choose to respond by the Web, you will be asked to enter a unique code from each of the duplicate surveys you receive.)

What if I have questions about this survey?

If you have any questions about this survey or about how to complete it electronically, please call Gallup Client Support (toll-free) at 1-888-297-8999, or send an e-mail to galluppoll@gallup.com.

Section A. Eligibility and Education

Please mark an "X" in the box corresponding to your answer in each question, or supply the requested information. Use blue or black ink.

EXAMPLE

RIGHT WAY ▼ ☒ 24 WRONG WAY ▼ ☒ 24

1 **As of March 10, 2004, were you actively licensed to practice as a registered nurse (RN) in any U.S. State or the District of Columbia (whether or not you were employed in nursing at that time)?** *(Please mark ☒ the appropriate box.)*

1 ☐ Yes ***(You are eligible to complete this questionnaire. Please continue to the next question.)***

2 ☐ No ***(You do not need to complete this questionnaire. Please stop here and return this questionnaire to Gallup so we know you are not eligible.)***

2 **Which initial educational program qualified you to sit for the RN licensure exam?** *(Mark one box.)*

1 ☐ Diploma Program
2 ☐ Associate Degree
3 ☐ Bachelor's Degree
4 ☐ Master's Degree
5 ☐ Doctorate (N.D.)

3 **In what month and year did you graduate from this program?**

Month ☐☐ Year ☐☐☐☐

4 **In which U.S. State (including the District of Columbia), U.S. Territory, or foreign country was this program located?**

☐

5 **In what U.S. State (or District of Columbia) were you issued your first RN license?**

State: ☐☐

Year: ☐☐☐☐

(PLEASE CONTINUE TO PAGE 2)

6 How did you finance your initial nursing education? *(Mark all that apply.)*

- 1 ☐ Personal resources (you or your spouse)
- 2 ☐ Family resources (parents or other relatives)
- 3 ☐ Employer tuition reimbursement plan (including Veterans Administration employer tuition plan)
- 4 ☐ Federal traineeship, scholarship, or grant
- 5 ☐ Federally-assisted loan
- 6 ☐ State/local government scholarship, loan, or grant
- 7 ☐ Non-government scholarship, loan, or grant
- 8 ☐ Other resources

7 At any time, have you ever been <u>licensed</u> as a practical or vocational nurse (LPN/LVN)?

- 1 ☐ Yes
- 2 ☐ No

8 Before starting your initial RN educational program, were you ever employed as any of the following: *(Mark all that apply.)*

- 0 ☐ No

- 1 ☐ Nursing Aide
- 2 ☐ Licensed Practical/Vocational Nurse (LPN/LVN)
- 3 ☐ Allied Health technician/technologist (e.g., radiologic technician)
- 4 ☐ Manager in health care setting
- 5 ☐ Clerk in health care setting
- 6 ☐ Another type of health-related position *(Please specify below.)*

9 Indicate all degrees you received <u>before</u> starting your initial RN educational program. *(Mark all that apply.)*

- 0 ☐ None ***(Skip to Question 11, page 3)***

- 1 ☐ Associate Degree
- 2 ☐ Bachelor's Degree
- 3 ☐ Master's Degree
- 4 ☐ Doctorate
- 5 ☐ Other *(Specify)*

10 What was the field of study for your highest degree identified in Question 9? *(Mark one box.)*

- 1 ☐ **Health-related field**

  or

  Non-Health related field

- 2 ☐ Biological or Physical Science
- 3 ☐ Business or Management
- 4 ☐ Education
- 5 ☐ Liberal Arts, Social Science, or Humanities
- 6 ☐ Law
- 7 ☐ Computer Science
- 8 ☐ Social Work
- 9 ☐ Other non-health-related field *(Please specify below.)*

(PLEASE CONTINUE TO PAGE 3)

11 **Did you earn any additional academic degrees AFTER graduating from your initial registered nurse education program that you described in Question 2?** *(Do not include degrees you are currently working towards.)*

1 ☐ Yes ***(Please complete all columns for each degree you earned.)***
2 ☐ No ***(Skip to Question 12, page 4)***

Type of Degree	A **Did you receive this degree?** *(Mark all that apply.)*	B **If so, did the degree enhance your nursing career?** *(Mark yes or no.)*	C **Which two-digit code from the table below best describes the primary focus of this degree?**	D **In what state or country did you receive the degree?**	E **In what year did you receive the degree?**
a. Associate Degree in nursing	☐	→	→		
b. Associate Degree in another field	☐	1 ☐ Yes 2 ☐ No	→		
c. Bachelor's degree in nursing	☐	→	→		
d. Bachelor's degree in another field	☐	1 ☐ Yes 2 ☐ No			
e. Master's in nursing (after any initial MSN mentioned in Question 2)	☐	→			
f. Additional Master's in nursing	☐	→			
g. Master's in another field	☐	1 ☐ Yes 2 ☐ No			
h. Doctorate in nursing	☐	→			
i. Doctorate in another field	☐	1 ☐ Yes 2 ☐ No			

For Column C, enter the appropriate two-digit code for each Bachelor's (other), Master's, or Doctorate degree above.

Primary Focus of Degree

01	Clinical Practice
02	Education
03	Supervision/Administration
04	Research
05	Law
06	Informatics
07	Business
08	Public Health
09	Social Science
10	Humanities
11	Basic Sciences (i.e., Biology)
12	Computer Science
13	Social Work
14	Other

12 **Since graduating from the initial nursing program you described in Question 2, have you completed a formal educational program preparing you for advanced practice nursing (APN) as a clinical nurse specialist, nurse anesthetist, nurse-midwife, or nurse practitioner?**

1 ☐ Yes ***(Please complete columns on pages 4-6 for each specialty you have obtained.)***

2 ☐ No ***(Skip to Question 13, Page 6)***

Information on Advanced Practice Nurse Preparation and Credentials	A Clinical Nurse Specialist (CNS)	B Nurse Anesthetist (NA)	C Nurse-Midwife (NM)	D Nurse Practitioner (NP)
12a Did you receive advance practice preparation as a …? *(Mark each column if yes.)*	↓ ☐	↓ ☐	↓ ☐	↓ ☐
12b What was the length of the program?	*(Mark one)*	*(Mark one)*	*(Mark one)*	*(Mark one)*
1. Less than 3 months	☐ 1	☐ 1	☐ 1	☐ 1
2. 3 through 8 months	☐ 2	☐ 2	☐ 2	☐ 2
3. 9 months or more	☐ 3	☐ 3	☐ 3	☐ 3
12c What was the highest credential you received in that program?	*(Mark one)*	*(Mark one)*	*(Mark one)*	*(Mark one)*
1. Certificate/Award	☐ 1	☐ 1	☐ 1	☐ 1
2. Bachelor's Degree	☐ 2	☐ 2	☐ 2	☐ 2
3. Master's Degree	☐ 3	☐ 3	☐ 3	☐ 3
4. Post-Master's Certificate	☐ 4	☐ 4	☐ 4	☐ 4
5. Doctorate	☐ 5	☐ 5	☐ 5	☐ 5
12d In what year did you receive this APN credential?	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
12e Which one of these was the primary specialty you studied?	*(Mark one)*	*(Mark one)*	*(Mark one)*	*(Mark one)*
1. Acute Care/Critical Care	☐ 01	☐ 01	☐ 01	☐ 01
2. Adult Health/Medical Surgical	☐ 02	☐ 02	☐ 02	☐ 02
3. Anesthesia	☐ 03	☐ 03	☐ 03	☐ 03
4. Community Health	☐ 04	☐ 04	☐ 04	☐ 04
5. Family	☐ 05	☐ 05	☐ 05	☐ 05
6. Geriatric/Gerontology	☐ 06	☐ 06	☐ 06	☐ 06
7. Home Health	☐ 07	☐ 07	☐ 07	☐ 07
8. Maternal-Child Health	☐ 08	☐ 08	☐ 08	☐ 08
9. Neonatal	☐ 09	☐ 09	☐ 09	☐ 09
10. Nurse-Midwifery	☐ 10	☐ 10	☐ 10	☐ 10
11. Obstetric/Gynecology	☐ 11	☐ 11	☐ 11	☐ 11
12. Occupational Health	☐ 12	☐ 12	☐ 12	☐ 12
13. Oncology	☐ 13	☐ 13	☐ 13	☐ 13
14. Palliative Care	☐ 14	☐ 14	☐ 14	☐ 14
15. Pediatrics	☐ 15	☐ 15	☐ 15	☐ 15
16. Psychiatric/Mental Health	☐ 16	☐ 16	☐ 16	☐ 16
17. Rehabilitation	☐ 17	☐ 17	☐ 17	☐ 17
18. School Health	☐ 18	☐ 18	☐ 18	☐ 18
19. Women's Health	☐ 19	☐ 19	☐ 19	☐ 19
20. Other (*Specify in appropriate column.*)	☐ 20 *(Specify)*	☐ 20 *(Specify)*	☐ 20 *(Specify)*	☐ 20 *(Specify)*

	A	B	C	D
Information on Advanced Practice Nurse Preparation and Credentials *(Question 12 continued from previous page.)*	**Clinical Nurse Specialist (CNS)**	**Nurse Anesthetist (NA)**	**Nurse-Midwife (NM)**	**Nurse Practitioner (NP)**
12f Is your current APN status certified by any of these national bodies? 1. American Association of Critical Care Nurses Certification Corp. 2. American Academy of Nurse Practitioners 3. American Association of Nurse Anesthetists 4. ACNM Certification Council, Inc. (ACC) (including previous ACNM certification) 5. American Nurses Credentialing Center (ANCC) 6. National Certification Board of Pediatric Nurse Practitioners & Nurses (NCPNP/N) 7. National Certification Corporation for the Obstetric, Gynecologist, and Neonatal Nursing Specialties (NCC) 8. Other *(Specify in appropriate column.)*	1 ☐ Yes 2 ☐ No *(Specify if other)* ☐	1 ☐ Yes 2 ☐ No *(Specify if other)* ☐	1 ☐ Yes 2 ☐ No *(Specify if other)* ☐	1 ☐ Yes 2 ☐ No *(Specify if other)* ☐
12g If Yes above, what is the primary type of national certification you have?	*(Mark one)*	*(Mark one)*	*(Mark one)*	*(Mark one)*
1. Acute Care NP	☐ 01	☐ 01	☐ 01	☐ 01
2. Acute Care/Critical Care (Adult) CNS	☐ 02	☐ 02	☐ 02	☐ 02
3. Acute Care/Critical Care (Pediatric or Neonatal) CNS	☐ 03	☐ 03	☐ 03	☐ 03
4. Adult NP	☐ 04	☐ 04	☐ 04	☐ 04
5. Certified Registered Nurse Anesthetist (CRNA)	☐ 05	☐ 05	☐ 05	☐ 05
6. Certified Nurse-Midwife (CNM)	☐ 06	☐ 06	☐ 06	☐ 06
7. Community Health CNS	☐ 07	☐ 07	☐ 07	☐ 07
8. Family NP	☐ 08	☐ 08	☐ 08	☐ 08
9. Gerontological CNS or NP	☐ 09	☐ 09	☐ 09	☐ 09
10. Home Health CNS	☐ 10	☐ 10	☐ 10	☐ 10
11. Medical Surgical CNS	☐ 11	☐ 11	☐ 11	☐ 11
12. Neonatal NP	☐ 12	☐ 12	☐ 12	☐ 12
13. Occupational Health NP	☐ 13	☐ 13	☐ 13	☐ 13
14. Pediatric CNS or NP	☐ 14	☐ 14	☐ 14	☐ 14
15. Palliative Care CNS or NP	☐ 15	☐ 15	☐ 15	☐ 15
16. Psychiatric & Mental Health–Adult NP or CNS	☐ 16	☐ 16	☐ 16	☐ 16
17. Psychiatric & Mental Health (Family) NP	☐ 17	☐ 17	☐ 17	☐ 17
18. Psychiatric & Mental Health Child/ Adolescent CNS	☐ 18	☐ 18	☐ 18	☐ 18
19. School NP	☐ 19	☐ 19	☐ 19	☐ 19
20. Women's Health Care NP (Ob-Gyn NP)	☐ 20	☐ 20	☐ 20	☐ 20
21. No National Certificate Exam Available	☐ 21	☐ 21	☐ 21	☐ 21
22. Other *(Specify in appropriate column.)*	☐ 22 *(Specify)* ☐	☐ 22 *(Specify)* ☐	☐ 22 *(Specify)* ☐	☐ 22 *(Specify)* ☐

Information on Advanced Practice Nurse Preparation and Credentials *(Question 12 continued from previous page.)*	A Clinical Nurse Specialist (CNS)	B Nurse Anesthetist (NA)	C Nurse - Midwife (NM)	D Nurse Practitioner (NP)
12h Do you have any current certification, licensure, or other official recognition of your APN status from any State Board of Nursing?	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

13 **Please identify any professional certifications in nursing you have received (e.g., critical care, emergency, oncology, case management, etc.). Do not include advanced practice nursing certifications reported above.**

0 ☐ None

Specify: _____

Specify: _____

Specify: _____

14 **Since January 2000, please indicate if you have received training in recognizing or responding to the following emergencies.** *(Mark all that apply.)*

0 ☐ None ***(Skip to Question 15)***

1 ☐ Biological attack
2 ☐ Chemical attack
3 ☐ Nuclear/radiologic attack
4 ☐ Infectious disease epidemics
5 ☐ Natural disaster or other public health emergencies

14a **(If you have marked any of the above types of training:) Please specify the TOTAL number of hours spent in the above training(s) since January 2000.**

☐☐☐ Hours in training

14b **Pertaining to the training in emergencies you marked above, will the training enable you to effectively participate in an organized multidisciplinary response to such an emergency?**

1 ☐ Yes
2 ☐ No

15 **Are you <u>currently</u> enrolled in a <u>formal</u> education program leading to an academic degree or certificate?**

1 ☐ Yes
2 ☐ No ***(Skip to Question 19, page 7)***

16 **Is this formal education program…?** *(Mark one box.)*

1 ☐ In nursing
2 ☐ In a non-nursing field useful to enhance your career in nursing
3 ☐ In another field to allow you to pursue career opportunities outside of nursing

17 **Are you a full-time or part-time student?**

1 ☐ Full-time student
2 ☐ Part-time student

18 **What type of degree/award are you currently working toward in this program?** *(Mark one box.)*

1 ☐ Associate Degree
2 ☐ Bachelor's Degree
3 ☐ Master's Degree
4 ☐ Doctorate
5 ☐ Certificate

(PLEASE CONTINUE TO PAGE 7)

Section B. Primary Nursing Employment

19 Are you employed or self-employed in nursing? *(Employment also includes: being on a temporary leave of absence from your nursing position; on vacation; being on sick leave; or working through a temporary employment service or practicing private duty nursing and not on a case at the moment.)*

1 ☐ Yes
2 ☐ No ***(Skip to Question 41, page 9)***

20 Are you required to maintain an active RN license in order to hold your principal nursing position? *(If you hold more than one nursing position, your principal nursing position is the one at which you work the most hours during your regular work year.)*

1 ☐ Yes
2 ☐ No

21 Where is the location of your principal nursing position? This information is critical for developing State employment estimates and supply and demand projections. *(If you are not employed in a fixed location, enter the geographic area where you spend most of your working time.)*

City/Town: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

County: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State (or country if not USA): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ZIP+4 code: ☐☐☐☐☐ – ☐☐☐☐ (if available)

22 In your principal nursing position, are you…? *(Mark one box.)*

1 ☐ An employee of the organization or facility for which you are working
2 ☐ Employed through an employment agency
3 ☐ Self-employed, per diem, or on as-needed basis

23 Using the list of NURSING EMPLOYMENT SETTINGS on page 15, write in the code that best describes your principal nursing employment setting. *(If you work in more than one setting, indicate the one setting in which you spend most of your working time.)*

☐☐☐ Code for employment setting from page 15

If this code is labeled as "Other," please specify the setting below.

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

24 Which one of the following best corresponds to the position title for your principal nursing position? *(Mark one box.)*

01 ☐ Administrator of organization/facility/agency or assistant administrator
02 ☐ Administrator of nursing or assistant (e.g., vice president for nursing, director or assistant director of nursing services)
03 ☐ Case manager
04 ☐ Certified nurse anesthetist (CRNA)
05 ☐ Charge nurse
06 ☐ Clinical nurse specialist
07 ☐ Consultant
08 ☐ Dean, director, or assistant/associate director of nursing education program
09 ☐ Float nurse
10 ☐ Discharge planner/outcomes manager
11 ☐ Head nurse or assistant head nurse
12 ☐ Infection control nurse
13 ☐ Informatics nurse
14 ☐ Instructor at a school of nursing
15 ☐ Insurance reviewer
16 ☐ Nurse clinician
17 ☐ Nurse coordinator
18 ☐ Nurse manager
19 ☐ Nurse-midwife
20 ☐ Nurse practitioner
21 ☐ Nursing staff development director
22 ☐ Nursing staff development instructor
23 ☐ Patient care coordinator
24 ☐ Private duty nurse
25 ☐ Professor or assistant/associate professor
26 ☐ Public health nurse
27 ☐ Quality improvement nurse
28 ☐ Researcher
29 ☐ School nurse
30 ☐ Staff nurse
31 ☐ Supervisor or assistant supervisor
32 ☐ Surveyor/auditor/regulator
33 ☐ Team leader
34 ☐ Traveling nurse
35 ☐ Visiting nurse/home health nurse
36 ☐ No position title
37 ☐ Other *(Specify)* ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

25 **For your principal nursing position, estimate the percentage of your time spent in the following activities during a usual workweek.** *(The total should equal 100%. Do not use decimal places.)*

a. Administration ..... ___ %

b. Consultation with agencies and/or professionals ..... ___ %

c. Direct patient care not including staff supervision ..... ___ %

d. Research ..... ___ %

e. Supervision/Management ..... ___ %

f. Teaching nursing or other health profession students (include class preparation time) ..... ___ %

g. Other ..... ___ %

TOTAL (confirm sum is 100%) ..... 1 0 0 %

26 **In a typical week in your principal nursing position, do you provide direct patient care in a hospital setting?** *(Exclude nursing home units. Include all clinics and other services of the hospitals.)*

1 ☐ Yes
2 ☐ No ***(Skip to Question 28)***

27 **During a typical workweek in your principal nursing position, in what type of unit do you spend the majority of your patient care time?** *(Mark one box.)*

01 ☐ Critical care unit (ICU/CCU)
02 ☐ Emergency department
03 ☐ General/specialty inpatient unit (other than critical care or step-down)
04 ☐ Home health care
05 ☐ Hospice unit
06 ☐ Labor/delivery room
07 ☐ Operating room
08 ☐ Outpatient department
09 ☐ Perioperative unit
10 ☐ Radiologic (diagnostic or therapeutic)
11 ☐ Step-down, transitional, progressive, telemetry unit
12 ☐ Sub-acute care unit

13 ☐ Multiple units, none over 50%
14 ☐ No specific assigned type of area
15 ☐ Other specific area *(Specify)*

28 **What type of patient is primarily treated in the unit/organization in which you work?** *(Mark one box.)*

01 ☐ No patient care – Unit/organization does not provide patient care

02 ☐ Adult care (general)
03 ☐ Cardiovascular
04 ☐ Chronic care
05 ☐ Neurological
06 ☐ Newborn
07 ☐ Obstetrics/gynecologic
08 ☐ Oncology
09 ☐ Orthopedic
10 ☐ Pediatric
11 ☐ Psychiatric
12 ☐ Rehabilitation
13 ☐ Renal

14 ☐ Work with multiple patient types
15 ☐ Other *(Specify)*

29 **In your principal nursing position, do you work…?** *(Mark one box.)*

1 ☐ The entire calendar year or school/academic year
2 ☐ Only part of the calendar year or school/academic year

30 **When you work at this principal nursing position, do you work…?** *(Mark one box.)*

1 ☐ Full-time
2 ☐ Part-time

31 **How many weeks do you normally work per year in this job?** *(Enter a number from 01 to 52.)*

___ weeks

32 **How would you best describe your feelings about your principal nursing position?** *(Mark one box.)*

1 ☐ Extremely dissatisfied
2 ☐ Moderately dissatisfied
3 ☐ Neither satisfied nor dissatisfied
4 ☐ Moderately satisfied
5 ☐ Extremely satisfied

33 Please provide information about the number of hours you worked in your last full workweek at your principal nursing position.

a) Number of hours worked in your last full workweek (including paid hours of on-call duty and overtime) ..... ☐☐

b) Number of hours reported in Item 33a that were paid on-call *(Enter 00 if none)* ..... ☐☐

c) Number of hours reported in Item 33a that were paid as overtime *(Enter 00 if none)* ..... ☐☐

d) Number of overtime hours reported in Item 33c that were mandatory/ unscheduled *(Enter 00 if none)* ..... ☐☐

34 Please estimate your current, gross annual earnings (pre-tax) from your principal nursing position. Include overtime and bonuses, but exclude sign-on bonuses.

$ ☐☐☐,☐☐☐.00 per year

35 Are you represented by a labor union in your principal nursing position?

1 ☐ Yes
2 ☐ No

Section C. Secondary Employment in Nursing

36 Aside from the principal nursing position you just described, do you hold any other positions in nursing for pay?

1 ☐ Yes
2 ☐ No ***(Skip to Question 43, page 10)***

37 In your other nursing position(s), are you...? *(Mark all that apply.)*

1 ☐ An employee of the organization or facility for which you are working
2 ☐ Employed through an employment agency
3 ☐ Self-employed, per diem, or on as-needed basis

38 What type of work setting best describes where you work for your other nursing position(s)? *(Mark one box. Refer to categories on page 15 for further clarification.)*

100 ☐ Hospital
200 ☐ Nursing home/extended care facility
300 ☐ Nursing education program
400 ☐ Public or community health setting
500 ☐ School health service
600 ☐ Occupational health
700 ☐ Ambulatory care setting
800 ☐ Insurance claims/benefits
900 ☐ Policy/planning/regulatory/licensing agency
950 ☐ Other

39 Which of the following categories best describes the amount you work in all of your other nursing position(s)? Your best estimate is fine. *(Note that 2,000 hours per year is full-time year-round. 1,000 hours per year is half-time year-round or full-time for half a year. 500 hours per year is 10 hours per week year round, or full-time for 3 months of the year.) (Mark one box.)*

1 ☐ Less than 500 hours per year
2 ☐ 500 hours per year
3 ☐ 501-999 hours per year
4 ☐ 1,000 hours per year
5 ☐ 1,001-1,499 hours per year
6 ☐ 1,500 hours per year
7 ☐ 1,501-1,999 hours per year
8 ☐ 2,000 hours per year or more

40 Please estimate your current, gross annual earnings (pre-tax) from your other nursing position(s).

$ ☐☐☐,☐☐☐.00 per year

Section D. Employment Outside of Paid Nursing

If you are currently working for pay in nursing, please skip to Question 43, Page 10.

41 If you are not working for pay in nursing, how long has it been since you last were employed or self-employed as a registered nurse?

0 ☐ Mark here if you never worked as a registered nurse
1 ☐ Mark here if less than one year
☐☐ Write in number of years if one or more

42 **What are the primary reasons you are not working in a nursing position for pay?** *(Mark yes or no for each item.)*

		Yes	No
a.	Burnout/stressful work environment	1 ☐	2 ☐
b.	Career change	1 ☐	2 ☐
c.	Difficult to find a nursing position	1 ☐	2 ☐
d.	Disability	1 ☐	2 ☐
e.	Illness	1 ☐	2 ☐
f.	Inability to practice nursing on a professional level	1 ☐	2 ☐
g.	Inadequate staffing	1 ☐	2 ☐
h.	Lack of advancement opportunities	1 ☐	2 ☐
i.	Lack of collaboration/communication between health care professionals	1 ☐	2 ☐
j.	Liability concerns	1 ☐	2 ☐
k.	Physical demands of job	1 ☐	2 ☐
l.	Retired	1 ☐	2 ☐
m.	Salaries too low/better pay elsewhere	1 ☐	2 ☐
n.	Scheduling/inconvenient hours/too many hours	1 ☐	2 ☐
o.	Skills are out-of-date	1 ☐	2 ☐
p.	Taking care of home and family	1 ☐	2 ☐
q.	Volunteering in nursing	1 ☐	2 ☐
r.	Went back to school	1 ☐	2 ☐
s.	Other *(Specify)* ☐		

43 **Are you currently employed in an occupation other than nursing?**

1 ☐ Yes
2 ☐ No ***(Skip to Question 49)***

44 **Is this employment with a health-related organization or in a health-related position?**

1 ☐ Yes
2 ☐ No

45 **Please provide a job title that best describes the nature of your <u>principal position outside of nursing</u>.** *(Write in job title in the space below.)*

☐

46 **Do you work full-time or part-time in this <u>principal position outside of nursing</u>?**

1 ☐ Full-time
2 ☐ Part-time

47 **What is the average number of hours you work per week in your <u>principal position outside of nursing</u>?**

☐☐ hours per week

48 **Please estimate your current, gross annual earnings (pre-tax) from your <u>principal position outside of nursing</u>.**

$ ☐☐☐,☐☐☐.00 per year

Section E. Plans for Employment in Nursing

49 **Are you actively seeking employment as a registered nurse?** *(Include seeking employment as an advanced practice nurse.)*

1 ☐ Yes
2 ☐ No ***(Skip to Question 52)***

50 **How long have you been actively seeking a nursing position?**

0 ☐ Mark here if less than one week

☐☐ Write in number of weeks if one or more

51 **Are you looking for a position that is…?**

1 ☐ Full-time
2 ☐ Part-time
3 ☐ Either

Section F. Prior Nursing Employment

52 **Since receiving your first RN license, how many years have you worked in nursing?** *(Only count years when you worked at least half the year in nursing.)*

0 ☐ Mark here if less than one year

☐☐ Write in number of years if one or more

53 **Were you employed in nursing one year ago?**

- [1] ☐ Yes
- [2] ☐ No ***(Skip to Question 61, page 12)***

54 **In your principal nursing position one year ago, did you work…?** *(Mark one box.)*

- [1] ☐ The entire calendar year or school/academic year
- [2] ☐ Only part of the calendar year or school/academic year

55 **When you worked at this principal nursing position one year ago, did you work…?** *(Mark one box.)*

- [1] ☐ Full-time
- [2] ☐ Part-time

56 **What was the location of your principal nursing position one year ago?** *(If you were <u>not</u> employed in a fixed location enter the geographic area where you spent most of your working time.)*

City/Town: _____

County: _____

State (or country if not USA): _____

ZIP+4 code: _____ – _____ (if available)

57 **In your principal nursing position one year ago, did you spend the majority of your working hours in inpatient units?**

- [1] ☐ Yes
- [2] ☐ No

58 **How would you describe your principal nursing position one year ago?**

- [1] ☐ Same position/same employer as current principal nursing position ***(Skip to Question 61, page 12)***
- [2] ☐ Different position/same employer as current one
- [3] ☐ Different employer than current one

59 **Were any of the following the <u>primary</u> reason(s) for this change?** *(Mark yes or no for each item.)*

	Yes	No
a. Burnout/stressful work environment	[1] ☐	[2] ☐
b. Career advancement/promotion	[1] ☐	[2] ☐
c. Disability	[1] ☐	[2] ☐
d. Illness	[1] ☐	[2] ☐
e. Interested in another position/job	[1] ☐	[2] ☐
f. Lack of collaboration/communication between health care professionals	[1] ☐	[2] ☐
g. Laid off/downsizing of staff	[1] ☐	[2] ☐
h. Opportunity to do the kind of nursing that I like	[1] ☐	[2] ☐
i. Pay/benefits better	[1] ☐	[2] ☐
j. Reorganization that shifted positions	[1] ☐	[2] ☐
k. Relocated to different geographic area	[1] ☐	[2] ☐
l. Retired	[1] ☐	[2] ☐
m. Scheduling/inconvenient hours/too many hours	[1] ☐	[2] ☐
n. Sign-on bonus offered	[1] ☐	[2] ☐

o. Other *(Specify)* _____

60 **Using the list of NURSING EMPLOYMENT SETTINGS on page 15, write in the code that <u>best</u> describes your principal nursing employment setting one year ago.** *(If you worked in more than one setting, indicate the <u>one</u> setting in which you spent most of your working time.)*

_____ Code for employment setting from page 15

If this code is labeled as "Other," please specify the setting below.

_____

(PLEASE CONTINUE TO PAGE 12)

Section G. General Information

Answers to the following questions will be used only to statistically interpret your responses.

61 Where do you currently reside? This information is critical for producing State estimates.

City/Town:

County:

State (or country if not USA):

ZIP+4 code: ____ – ____ (if available)

62 Did you reside in the same city/town a year ago?

1 ☐ Yes ***(Skip to Question 64)***
2 ☐ No

63 Where did you reside a year ago? This information is critical for producing State estimates.

City/Town:

County:

State (or country if not USA):

ZIP+4 code: ____ – ____ (if available)

64 What is your gender?

1 ☐ Male
2 ☐ Female

65 What is your year of birth?

1 9 ☐ ☐

66 What is your ethnic background?

1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

67 What is your racial background? *(Mark one or more races.)*

1 ☐ American Indian or Alaska Native
2 ☐ Asian
3 ☐ Black or African American
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ White
6 ☐ Other *(Specify)*

68 What languages do you speak fluently other than English? *(Enter all that apply.)*

0 ☐ No other languages
1 ☐ Language #1
2 ☐ Language #2
3 ☐ Language #3

69 Which best describes your current marital status?

1 ☐ Now married
2 ☐ Widowed, divorced, or separated
3 ☐ Never married

70 Describe the children/parents/dependents who either live at home with you or for whom you provide a significant amount of care. *(Mark all that apply.)*

1 ☐ No children/parents/dependents at home
2 ☐ Child(ren) less than 6 years old at home
3 ☐ Child(ren) 6 to 18 years old at home
4 ☐ Other adults at home (i.e., parents or dependents)
5 ☐ Others living elsewhere (i.e., children, parents or dependents)

71 What is your current, gross annual household income (pre-tax)?

1 ☐ $15,000 or less
2 ☐ $15,001 to $25,000
3 ☐ $25,001 to $35,000
4 ☐ $35,001 to $50,000
5 ☐ $50,001 to $75,000
6 ☐ $75,001 to $100,000
7 ☐ $100,001 to $150,000
8 ☐ More than $150,000

Section H. Licensure Information

Answers to the following questions will be kept strictly confidential under Federal Law 42 USC 295k, section 792 of the U.S. Public Health Service (PHS) Act and will only be used to develop accurate estimates of the number of RNs in the country and in each State.

72 **Please provide the information on the State(s) in which you hold an active RN license. This information is critical to confirm that you are the individual we intended to complete the survey, not just someone with a similar name, and that you still hold an active license.**

	A	B	C	D
	State of licensure	Permanent number on certificate of registration	What is the last name on the license?	What is the first name on the license?	What is the middle initial on the license?
1.	☐☐				
2.	☐☐				
3.	☐☐				
4.	☐☐				
5.	☐☐				

Section I. Contact Information/Comments

73 **If we need to contact you about any of your responses, please provide your e-mail address and telephone number, as well as the best time of day to reach you.**

E-mail address:

Telephone No.: (☐☐☐) ☐☐☐ - ☐☐☐☐

Area Code Telephone Number

☐ Home ☐ Work ☐ Cell

Time of day/week best to contact you by phone:

74 **Do you have any recommendations for how this survey could be improved? Please print clearly.**

Thank you! Please return this survey and any duplicate surveys in the enclosed postage-paid envelope.

NURSING EMPLOYMENT SETTINGS & CODES

(Use this list for Questions 23 and 60)

CODE

Hospital (Exclude nursing home units and all off-site units of hospitals, but include all on-site clinics and other services of the hospitals.)

Non-Federal, short-term hospital, except psychiatric (for example, acute care hospital) ..110
Non-Federal, long-term hospital, except psychiatric 120
Non-Federal psychiatric hospital 130
Federal Government hospital 140
Other type of hospital 150

Nursing Home/Extended Care Facility

Nursing home unit in hospital 210
Other nursing home 220
Facility for mentally retarded 230
Other type of extended care facility 240

Nursing Education Program

LPN/LVN program 310
Diploma program (RN) 320
Associate degree program 330
Bachelor's and/or higher degree nursing program 340
Other program 350

Public or Community Health Setting

Official State Health Department 402
Official State Mental Health Agency 405
Official City or County Health Department 410
Combination (official/voluntary) nursing service ..415
Visiting nurse service (VNS/NA) 420
Home health service unit (hospital-based) 422
Home health agency (non-hospital based) 425
Community mental-health organization or facility (including freestanding psychiatric outpatient clinics) 430
Substance abuse center/clinic 431
Community/neighborhood health center 435
Planned Parenthood/family planning center 440
Day care center 445
Rural health care center 450
Retirement community center 455
Hospice 460
Other 465

CODE

School Health Service

Public school system 510
Private or parochial elementary or secondary school ... 520
College or university 530
Other 540

Occupational Health (Employee Health Service)

Private industry 610
Government 620
Other 630

Ambulatory Care Setting

Solo practice (physician) 710
Solo practice (nurse) 715
Partnerships (physicians) 720
Partnerships (nurses) 725
Group practice (physicians) 730
Group practice (nurses) 735
Partnership or group practice (mixed group of professionals) 740
Freestanding clinic (physicians) 750
Freestanding clinic (nurses) 755
Ambulatory surgical center 760
Dialysis center/clinic 761
Dental practice 770
Hospital owned off-site clinics 775
Health Maintenance Organization (HMO) 780
Other 790

Insurance Claims/Benefits

Government 810
State or local agencies 820
Insurance company 830
Private industry/organization 840

Policy, Planning, Regulatory, or Licensing Agency

Central or regional Federal agency 910
State Board of Nursing 920
Nursing or health professional membership association 930
Health planning agency, non-Federal 940
Other 945

Other

Correctional facility 950
Private duty in a home setting 955
Home-based self-employment 960
Other 965