MDS: DENTAL HYGIENISTS

Demographics

1. Birth date [Day] [Month] [Year]

2. Sex: O Male O Female

3. Ethnicity
   Are you Hispanic or Latino? O Yes O No

4. Race (Check all that apply.)
   O American Indian or Alaska Native O Asian
   O Black or African American O Native Hawaiian or Other Pacific Islander
   O White O Choose not to respond

5. Where were you born?
   O In the United States (Print state/territory abbreviation): [State]
   O Outside the United States (Print name of foreign country): ______________________

Education & Training

6. What is your highest dental hygiene degree?
   O Certificate/Diploma O Associate degree
   O Bachelor’s degree O Master’s degree

7. What year did you complete your dental hygiene education? [Year]

8. Where did you complete your dental hygiene education?
   O United States (specify state): [State]
   O Outside the United States (Print name of foreign country): ______________________

9. What is your highest non-dental hygiene degree?
   O Certificate/Diploma O Master’s degree
   O Associate degree O Doctoral degree
   O Bachelor’s degree

10. What field is the degree in? ________________________________
Practice Characteristics

11. What is your employment status? (mark all that apply)
   - Actively working in a position that requires a dental hygiene license
   - Actively working in a dental hygiene related field that does not require a dental hygiene license
   - Actively working in a field that does not require a dental hygiene license
   - Not currently working, disabled
   - Not currently working, seeking work in a position that requires a dental hygiene license
   - Not currently working, seeking work in a position that does not require a dental hygiene license
   - Student
   - Leave of absence or Sabbatical
   - Retired

12. If you are not currently working in dental hygiene, are you planning on returning in the next 12 months?
   - Yes  
   - Unsure  
   - No  

13. Which best describes the type of setting that most closely corresponds to your principal and secondary (if applicable) direct patient care practice location(s): (Select One Principal and One Secondary if applicable.)

<table>
<thead>
<tr>
<th>Private Stand Alone Dental Hygiene Practice</th>
<th>Principal</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental office practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solo practice</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Partnership</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Group practice (single specialty)</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Group practice (multiple specialties)</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Practices</th>
<th>Principal</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care self employed</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Oral and Maxillofacial Pathology</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Orthodontics and Dentofacial Orthopedics</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Periodontics</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Endodontics</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Oral and Maxillofacial Surgery</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Oral and Maxillofacial Radiology</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Other Specialty</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Hospital/Clinic</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Federal Government Hospital/Clinic</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Health Center (CHC/FQHC/FQHC look-alike)</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Long Term Care/Nursing home/Extended Care Facility (non-hospital)</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Home health setting</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Local health department</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Other Public Health/Community Health Setting</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>School health service</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Mobile Unit Dentistry</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Correctional Facility</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Indian Health Service</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Headstart (including early Headstart)</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Staffing organization</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Other setting (specify):___________________</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

September 1, 2013 2
14. How many weeks did you work in dental hygiene in the past year? □□

15. For all positions held, indicate the average number of hours spent per week on each Dental Hygiene major activity:

<table>
<thead>
<tr>
<th>Direct Patient Care</th>
<th>Research</th>
<th>Education</th>
<th>Administration</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>□□</td>
<td>□□</td>
<td>□□</td>
<td>□□</td>
<td>□□</td>
</tr>
</tbody>
</table>

16a. Are you currently working as many hours as you would like in dental hygiene? O Yes O No

16b. If NO, how many more hours a week would you like to be working in dental hygiene? □□

**The remaining items should be completed only by dental hygienists practicing **direct patient care**.**

17. What state(s) are you currently practicing in?

□□ □□ □□

18. Direct Patient Care: Practice Locations

What is the location of sites where you spend the most time providing direct patient care:

Principal practice site
Zip Code of practice site: □□□□□
Direct care hours at site*: □□

Secondary Practice Site (if applicable)
Zip Code of practice site: □□□□□
Direct care hours at site*: □□

OPTIONAL:

18. Direct Patient Care: Practice Locations

What is the location of sites where you spend the most time providing direct patient care:

Principal Location Address

__________________________  __________________________
Number   Street

__________________________
City/Town   State

Zip Code □□□□□

Secondary Location Address (if applicable)

__________________________
Number   Street
<table>
<thead>
<tr>
<th>City/Town</th>
<th>State</th>
</tr>
</thead>
</table>

Zip Code: [ ] [ ] [ ] [ ] [ ]

19. **Is your principal practice site formally affiliated with a network of other practices or health providers?**
   - O No
   - O Yes, Staff Model HMO
   - O Yes, Dentist-Hospital Organization
   - O Yes, Independent Practice Association
   - O Yes, Federally Qualified Health Center
   - O Yes, other: ______________________

20. **What are your employment plans for the next 12 months?**
   - O Increase hours in patient care
   - O Decrease hours in patient care
   - O Seek employment in a field outside of patient care
   - O Leave direct patient care to complete further training
   - O Leave direct patient care for family reasons/commitments
   - O Leave direct patient care due to physical demands
   - O Leave direct patient care due to stress/burnout
   - O Retire
   - O Continue as you are
   - O Unknown
OPTIONAL

21. Which of the following best describes your current employment arrangement at your principal practice location?
   O Self employed
   O Salaried employment
   O Hourly employment
   O Temporary/Fill-in work
   O Other (specify): _____________________

22. Please indicate if you are currently practicing under the following:
   O Direct supervision – dentist is present
   O Prescriptive supervision – dentist is not present, but authorized treatment
   O None of the above

23. Number of Dental Hygienists at each practice location:

   Principal  □□□□  Secondary  □□□□

24. Number of Dentists at each practice location:

   Principal  □□□□  Secondary  □□□□

25. Are you able to communicate with patients in a language other than English without using an interpreter?
   O Yes  O No

   If yes – What language(s)? _____________________