WASHINGTON Medical Commission

Washington State Medical Commission

Certified Anesthesiologist Assistant Census for Workforce Planning

I: Certified Anesthesiologist Assistant Information

1. Last Name_____ 2. First Name_____ 3. Middle Name_____

4. Date of Birth (mm/dd/yyyy) ____/____/ _____ 5. Sex ☐ Male ☐ Female ☐ X ☐ Prefer not to answer

6. How would you classify your race/ethnicity? Please check all that apply.

☐ White
☐ Black or African American
☐ Middle Eastern or North African
☐ American Indian or Alaska Native
☐ Asian
☐ Prefer not to answer
☐ Native Hawaiian / other Pacific Islander
☐ Hispanic or Latino
☐ Other (Specify)_____

7. Are you a member of a Washington State tribe? ☐ No ☐ Yes: Which tribe? _____

8. What is your NPI number? _____ ☐ I do not have a NPI number

9. Do you currently reside in Washington State? ☐ Yes ☐ No

10. Residence City _____ 11. Residence State _____ 12. Residence Zip Code _____

13. In what US state did you obtain your Master of Science degree? _____

II: Practice Information

14. Are you retired from clinical practice?
☐ No
☐ Yes (Skip to question 27)

15. Do you plan to retire from clinical practice in the next 12 months?
☐ No (Skip to question 17)
☐ Yes

16. Upon retirement, will you convert your license to retired status?
☐ Yes
☐ No: Why will you not convert your license? _____

17. For patient-related activities, indicate your practice arrangement. Please check all that apply.
☐ Academically affiliated practice
☐ Clinical training site
☐ Single Specialty Group
☐ Multi-Specialty Group
☐ Employee of a hospital or clinic
☐ State or Federal Employer
☐ Other: Please describe _____

18. Which best describes your primary clinical practice? Please check only one.
☐ Office based
☐ Hospital based
☐ Freestanding ambulatory surgery center
☐ Critical access center
☐ Pain clinic
☐ Other: Please describe _____

19. Do you currently practice in Washington State?
☐ Yes
☐ No (Skip to question 21)

20. Is this your primary clinical practice location?
☐ Yes
☐ No

21. How many locations do you practice at? _____

22. Please list your primary worksite(s).

	Location *(Street Address)*	City	State	Zip Code
Site (1)				
Site (2)				
Site (3)				

23. How many supervising anesthesiologists do you have? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

24. Is your supervising anesthesiologist accepting new patients covered by the following?

	Yes	No	I do not know
Medicare	☐	☐	☐
Medicaid/ Apple Health	☐	☐	☐
Tricare	☐	☐	☐

25. Are language interpretation services offered at your practice?
☐ No
☐ Yes: What languages are offered for interpretation (via phone, in person, staff etc.) at your practice?
☐ English ☐ Korean ☐French ☐ Spanish ☐ Russian ☐ Mandarin Chinese ☐ Other_____

26. Do you speak any language(s) other than English well enough to communicate with your patients?
☐ None ☐ Korean ☐French ☐ Spanish ☐ Russian ☐ Mandarin Chinese ☐ Other _____

27. In the past 12 months, how many weeks did you work or volunteer in a clinical setting? For example, if you took 2 weeks of vacation and worked the rest of the year, enter 50 weeks. _____

28. How many hours per week do you typically dedicate to the following activities:

- Clinical (not volunteer) _____/hours per week
- Research _____/hours per week
- Administration (committees, management) _____/hours per week
- Education (preceptor, clinical professor) _____/hours per week
- Volunteer Clinical _____/hours per week
- Regular in-house calls_____/hours per week
- Other _____/hours per week. Please describe: _____

29. Do you provide telehealth / telemedicine services as defined below?
RCW 18.134.010(9) "Telehealth" includes telemedicine and means the use of synchronous or asynchronous telecommunication technology by a practitioner to provide health care to a patient at a different physical location than the practitioner. "Telehealth" does not include the use, in isolation, of email, instant messaging, text messaging, or fax.
☐ No
☐ Yes: a) How many hours per week do you practice telehealth/telemedicine? _____
b) Please describe the setting in which you practice telehealth/telemedicine
_____
c) What percentage of your telemedicine/telehealth patients live in Washington State? _____%

30. Do you treat patients using non-traditional therapies? (e.g. complementary or alternative medicine, natural, homeopathic)
☐ No
☐ Yes: Please describe. _____

Part III: Contact Information

Do you have any comments regarding your current practice you would like to share?

Please enter contact information should our office have questions.

Name _____

Title _____

Phone Number _____

Email Address_____

Have you completed this census on behalf of another person?
☐ No
☐ Yes: Name of the person completing this census _____

Name of the licensee for whom this census was completed _____

Return to: Washington Medical Commission (WMC), PO Box 47866, Olympia, WA 98504-7866

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Website: www.wmc.wa.gov/demographics