

WEST VIRGINIA DENTAL CENSUS REPORT DENTIST SURVEY

The West Virginia Board of Dental Examiners in cooperation with West Virginia University School of Dentistry and the West Virginia Department of Health and Human Resources-Oral Health Program, request the following information be completed **and returned with your re-licensure application.**

As dentists and dental hygienists graduate each year from West Virginia accredited schools, many leave the state to gain employment. **The purpose of this census is to match new dental and dental hygiene graduates with dental practitioners that are actively seeking an associate or dental hygienist and to gather information on clinically active dentists by county.** You do not need to complete the census report for re-licensure; however, the information you provide will be very helpful and utilized to achieve our goals as outlined above.

1. WHICH DENTAL SCHOOL AND WHAT YEAR WERE YOU AWARDED YOUR D.D.S. OR D.M.D. DEGREE?

- WVU SCHOOL OF DENTISTRY YEAR: _____
- OTHER: _____ YEAR: _____

YEAR OF BIRTH:

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 GENDER: MALE FEMALE

- RACE:
- WHITE BLACK/AFRICAN AMERICAN
- AMERICAN INDIAN/ALASKA NATIVE ASIAN
- NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- OTHER: _____

2. IF YOU CURRENTLY HAVE A WEST VIRGINIA LICENSE, BUT DO NOT PRACTICE DENTISTRY, PLEASE INDICATE WHY. (CHOOSE ONLY ONE)

- RETIRED
- SALARY
- MALPRACTICE INSURANCE RATES
- LIABILITY EXPOSURE
- UNABLE TO SECURE EMPLOYMENT
- OTHER, PLEASE LIST: _____

3. ARE YOU CURRENTLY SEEKING ANY ADDITIONAL DENTAL EMPLOYMENT?

- NO
- IF YES, PLEASE LIST IN WHAT COUNTY(S) AND HOW MANY ADDITIONAL HOURS A WEEK YOU ARE SEEKING?
- COUNTY(S): _____ HOURS:
- 1-4 HRS 15-19 HRS
- 5-9 HRS 20-24 HRS
- 10-14 HRS 25+ HRS

4. WHAT KIND(S) OF DIFFICULTY (IF ANY) HAVE YOU EXPERIENCED IN FINDING A POSITION AS A DENTIST? (CHECK ALL THAT APPLY)

- NONE
- LOOKING FOR FULL TIME EMPLOYMENT AND CANNOT FIND IT
- LOOKING FOR PART TIME EMPLOYMENT AND CANNOT FIND IT
- THE DAY(S) REQUIRED WERE UNAVAILABLE
- INADEQUATE SALARY
- INADEQUATE BENEFITS
- UNSATISFACTORY WORK ENVIRONMENT
- TRAVEL TIME-DISTANCE IS TOO GREAT
- OTHER: _____

5. PLEASE INDICATE FROM THE CHOICES BELOW, WHICH AREA(S) YOU WOULD LIKE TO RECEIVE CONTINUING EDUCATION.

- YOUNG CHILDREN BIRTH TO FIVE
- WOMEN'S PERINATAL HEALTH
- CHILDREN AND ADULTS WITH SPECIAL NEEDS
- PRACTICE MANAGEMENT
- GERIATRIC DENTISTRY
- OTHER: _____

IF YOU ARE NOT CURRENTLY PRACTICING, YOUR SURVEY ENDS HERE. PLEASE SEE HIGHLIGHTED INFORMATION ON PAGE 2. IF YOU HAVE A LICENSE AND ARE CURRENTLY PRACTICING, PLEASE CONTINUE WITH THE REST OF THE SURVEY.

6. WHICH ONE OF THE FOLLOWING BEST DESCRIBES YOUR PRACTICE, RESEARCH OR ADMINISTRATION AREA?

- GENERAL DENTISTRY
- PEDIATRIC DENTISTRY
- ENDODONTICS
- ORTHODONTICS
- PERIODONTICS
- PROSTHODONTICS
- ORAL AND MAXILLOFACIAL SURGERY
- ORAL AND MAXILLOFACIAL RADIOLOGY
- DENTAL PUBLIC HEALTH
- EDUCATOR/ACADEMIC APPOINTMENT
- OTHER: _____

7. WHICH OF THE FOLLOWING BEST DESCRIBES YOUR PRACTICE, RESEARCH OR ADMINISTRATION AREA? (PLEASE MARK ONLY ONE)

- SOLO PRACTICE
- GROUP PRACTICE
- VA HOSPITAL OR MILITARY
- FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
- ACADEMIC SETTING/TEACHING
- STATE OR LOCAL GOVERNMENT
- OTHER, PLEASE LIST: _____

8. IF YOUR PRIMARY OCCUPATION IS A PRIVATE PRACTICING DENTIST, WHICH ONE OF THE FOLLOWING BEST DESCRIBES YOU IN YOUR PRIMARY PRACTICE WHERE YOU WORK?

- OWNER (SOLE OWNER, PARTNER OR SHAREHOLDER)
- NONOWNER (EMPLOYED) DENTIST
- ASSOCIATE DENTIST (NONOWNER)
- INDEPENDENT CONTRACTOR
- OTHER, PLEASE SPECIFY _____

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9. HOW MANY YEARS HAVE YOU BEEN IN YOUR CURRENT PRIMARY PRACTICE SETTING AND/OR POSITION?
- 0-1 YEAR
 2-5 YEARS
 6-10 YEARS
 11-15 YEARS
 16-20 YEARS
 GREATER THAN 20 YEARS
10. ARE YOU CURRENTLY ACCEPTING NEW PATIENTS?
 YES NO
11. PLEASE LIST THE COUNTY/COUNTIES IN WHICH YOU ARE CURRENTLY PRACTICING and THE NUMBER OF HOURS PRACTICED IN EACH LOCATION PER WEEK.
- _____ COUNTY _____ HOURS/WEEK
 _____ COUNTY _____ HOURS/WEEK
 _____ COUNTY _____ HOURS/WEEK
12. APPROXIMATELY HOW MANY PATIENTS DO YOU TREAT PER MONTH?
- 0 PATIENTS/MONTH
 1-10 PATIENTS/MONTH
 11-20 PATIENTS/MONTH
 21-50 PATIENTS/MONTH
 51-100 PATIENTS/MONTH
 GREATER THAN 100 PATIENTS/MONTH
13. DO YOU CURRENTLY EMPLOY A DENTAL HYGIENIST?
 YES IF YES HOW MANY _____ FULL-TIME _____ PART-TIME
 NO IF NOT, PLEASE INDICATE WHY?
 NONE AVAILABLE
 CANNOT AGREE UPON COMPENSATION
 PERSONAL CHOICE
 PATIENT BASE DOES NOT SUPPORT EMPLOYING A DENTAL HYGIENIST
 OTHER, PLEASE LIST _____
14. PLEASE CHECK ALL GOVERNMENT SPONSORED PROGRAMS IN WHICH YOU CURRENTLY PARTICIPATE.
- CHIP
 ADULT MEDICAID - EMERGENCIES
 DONATED DENTURE PROGRAM
 MEDICAID - CHILD
 PRE-EMPLOYMENT PROGRAM (TANF)
 WORKER'S COMPENSATION
 OTHER, PLEASE LIST _____
15. APPROXIMATELY HOW MANY MEDICAID PATIENTS DO YOU TREAT EACH MONTH?
- 0 PATIENTS/MONTH 21-50 PATIENTS/MONTH
 1-10 PATIENTS/MONTH 51-100 PATIENTS/MONTH
 11-20 PATIENTS/MONTH 100+ PATIENTS/MONTH
16. ARE YOU ACCEPTING NEW MEDICAID PATIENTS?
 YES NO
17. IF NOT, WHICH OF THE FOLLOWING REASONS MIGHT BEST EXPLAIN WHY YOU ARE NOT ACCEPTING NEW MEDICAID PATIENTS? (CHECK ALL THAT APPLY)
- LOW COMPENSATION
 BILLING REQUIREMENTS
 TOO MUCH PAPERWORK
 PRACTICE IS AT FULL CAPACITY
 CONCERNED ABOUT FRAUD ISSUES
 CONCERNED ABOUT LIABILITY ISSUES
 MEDICAID DOES NOT COVER SPECIALITY OR ADULT PRACTICE SERVICES
 HIGH NUMBER OF BROKEN APPOINTMENTS
 OTHER: _____
18. DO YOU PLAN TO: (CHECK ONLY ONE CHOICE)
- RETIRE OR LEAVE YOUR PRACTICE IN LESS THAN ONE YEAR
 RETIRE OR LEAVE YOUR PRACTICE IN THE NEXT 1-5 YEARS
 RETIRE OR LEAVE YOUR PRACTICE IN THE NEXT 6-10 YEARS
 APPRECIABLY REDUCE HOURS WITHIN THE NEXT 5 YEARS
 I HAVE NO PLANS TO RETIRE OR LEAVE WITHIN THE NEXT 10 YRS
19. HAVE YOU TRIED TO RECRUIT A DENTIST TO YOUR PRACTICE DURING THE LAST TWO YEARS?
 YES, WITH SUCCESS
 YES, WITHOUT SUCCESS
 NO, BUT I WOULD LIKE TO RECRUIT A DENTIST
 NO, NOT INTERESTED OR APPLICABLE

FOR MORE INFORMATION ON PRACTICE OPPORTUNITIES, PLEASE CONTACT THE SCHOOL OF DENTISTRY @ 304 293-5912 RMECKSTROTH@HSC.WVU.EDU OR YOU CAN USE THE SPACE BELOW TO PROVIDE YOUR CONTACT INFORMATION IF YOU WOULD WISH FOR THE WVU SCHOOL OF DENTISTRY TO FOLLOW UP WITH YOU REGARDING POTENTIAL MATCHING OPPORTUNITIES. **THANK YOU FOR YOUR SUBMISSION AND RETURN THIS SURVEY WITH YOUR LICENSE RENEWAL TO THE WEST VIRGINIA BOARD OF DENTAL EXAMINERS.**

FIRST NAME:

LAST NAME:

MAILING ADDRESS: STATE: ZIP CODE:

COUNTY OF RESIDENCE:

PHONE NUMBER: () -

EMAIL: