

# DENTAL HEALTHCARE WORKFORCE SURVEY

Pursuant to Business and Professions Code section 1715.5, the Dental Board requires completion of sections 1, 2, 3, 4, and 5 of this survey. The survey information collected will be publicly available in accordance with state law.

LICENSE NUMBER:

**1. LICENSE TYPE**

- DDS
- RDH
- RDHEF
- RDHAP
- RDA
- RDAEF

**2. EMPLOYMENT STATUS**

- Full-time clinical practice in CA (32+ hours per week)
- Full-time clinical outside CA (32+ hours per week)
- Part-time clinical practice in CA (less than 32 hours per week)
- Administrative/Faculty Employment (No Direct Patient Care)
- Retired
- Other practice or employment status

**3(a). PRIMARY PRACTICE LOCATION**

If you provide patient care, please indicate the zip code of your primary practice location (U.S. only) and the number of hours spent each week at this location.

**ZIP CODE**

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**HOURS PER WEEK**

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**3(b). SECONDARY PRACTICE LOCATION**

If you provide patient care in a second location, please indicate the zip code of that practice location (U.S. Only) and the number of hours spent each week at this location.

**ZIP CODE**

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**HOURS PER WEEK**

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**4. POSTGRADUATE TRAINING** Indicate the total years of training completed after dental school (accredited by the Committee on Dental Accreditation in a dental specialty recognized by the American Dental Association)

- 1    2    3    4    5+    None

**5. DENTAL PRACTICE/SPECIALTY and BOARD CERTIFICATION or PERMITS** mark specialty classifications and Board Certifications:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> General Practice | <input type="checkbox"/> Endodontics             | <input type="checkbox"/> Oral Radiology      | <input type="checkbox"/> General Anesthesia      |
| <input type="checkbox"/> Prosthodontics   | <input type="checkbox"/> Public Health           | <input type="checkbox"/> Pediatric Dentistry | <input type="checkbox"/> Oral Conscious Sedation |
| <input type="checkbox"/> Maxillofacial    | <input type="checkbox"/> Orthodontics            | <input type="checkbox"/> Periodontics        | <input type="checkbox"/> Conscious Sedation      |
| <input type="checkbox"/> Oral Pathology   | <input type="checkbox"/> Facial Cosmetic Surgery |  |  |

**6. ETHNIC BACKGROUND (Optional)** Mark all that apply

- African American/Black/African    Caucasian/White/European/Middle Eastern    Decline to State  
 American Indian/Native American/Alaskan Native    Other (not listed)

**Asian**

- Cambodian    Japanese    Thai  
 Chinese    Korean    Vietnamese  
 Indian    Laotian/Hmong    Other Asian  
 Indonesian    Pakistani

**Latino/Hispanic**

- Central American    Cuban  
 South American    Mexican  
 Puerto Rican    Other Hispanic

**Native Hawaiian/Pacific Islander**

- Fijian    Samoan  
 Filipino    Tongan  
 Guamanian    Other Pacific Islander  
 Hawaiian

**7. FOREIGN LANGUAGE (Optional)**

- American Sign Language    Japanese  
 Arabic    French  
 Armenian    German  
 Cambodian    Hebrew  
 Hindi

**In addition to English, indicate additional languages in which you are fluent.**

- Thai    Central American    Punjabi    Thai  
 Ilocano    Mandarin    Russian    Turkish  
 Italian    Mien    Samoan    Vietnamese  
 Japanese    Polish    Spanish    Decline to State  
 Korean    Portuguese    Tagalog    Other \_\_\_\_\_

Return the completed survey via mail to the Dental Board of California 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or via fax to (916) 274-5970.