

## Focus Group Participant Information Questionnaire Facility Staff

Please complete this questionnaire. This information will be used only for summarizing participant information at this meeting. Please DO NOT write your name or address on this questionnaire.

Date: \_\_\_\_\_

Time: \_\_\_\_\_

1. I am the:

- Physician
- Licensed Nurse
- Nursing Assistant/Aide
- Direct Care Staff (e.g., Dietician, Pharmacist, Social Worker)
- Activities Directors/Staff
- Other: \_\_\_\_\_

2. I work in a:

- Nursing home
- Board and care home (assisted living, residential care, and other non-nursing home settings)
- Other: \_\_\_\_\_

3. I have been in this role for: \_\_\_\_\_ years \_\_\_\_\_ months

4. I am:

- Male
- Female

**THANK YOU FOR YOUR HELP!**

INSERT OMB INFORMATION HERE
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