

Evaluation of Workplace-based Quit Smoking Programs

Employee Needs Assessment Survey

Information about You and Your Work

Please check your answer ☒ or write your answer in the spaces provided.

Your unique code

To connect with other surveys you may complete for this project, we create a unique and anonymous code. Below, please note your birth day and month and the initial of your Mother's first name.

<i>Your Birth date</i>		
<i>Day</i>	<i>Month (1-12)</i>	<i>First Initial of your Mother's FIRST name</i>
<i>14</i>	<i>6</i>	<i>(e.g., Julie) J</i>

(example)

Please complete
➔

➔ Today's date: _____

➔ Name of the Organization and Department you work for?

1. What is your job? **(Please check ONE that applies)**

1. ☐ Construction worker
2. ☐ Customer service/reception
3. ☐ Factory worker
4. ☐ Food and beverage services/chef/cook
5. ☐ Housekeeping staff
6. ☐ Facility staff
7. ☐ Office clerk/administrative support
8. ☐ Other clerk
9. ☐ Sales
10. ☐ Senior management
11. ☐ Supervisor/middle and other management
12. ☐ Security guard
13. ☐ Stock/shipping/receiving clerk
14. ☐ Other, please give details _____

2. What is your job status at this workplace? **(Check ONE that applies)**

1. ☐ Full-time permanent
2. ☐ Full-time temporary (seasons, term or contract)
3. ☐ Part-time permanent
4. ☐ Part-time temporary (seasonal, term or contract)
5. ☐ Casual/other (full-time or part-time)
6. ☐ Other, please specify _____

3. What is your typical work schedule? **(Check ONE that applies)**

1. ☐ Business hours (Monday- Friday 9:00-5:00)
2. ☐ Shift work, please give details _____
3. ☐ Weekend work, please give details _____
4. ☐ Other, please give details _____

Please turn over the page

4. On a typical day at work, where do you spend your time? **Please check all that apply AND write the times as a percent (%) of a typical working day.**

Example:

1.	<input checked="" type="checkbox"/>	Inside	40	% of day
2.	<input checked="" type="checkbox"/>	Outside	50	% of day
3.	<input checked="" type="checkbox"/>	In a vehicle	10	% of day
4.	<input type="checkbox"/>	Other, specify details	0	
			100%	

On a typical day at work, where do you spend your time? Please complete:

1.	<input type="checkbox"/>	Inside	_____	% of day
2.	<input type="checkbox"/>	Outside	_____	% of day
3.	<input type="checkbox"/>	In a vehicle	_____	% of day
4.	<input type="checkbox"/>	Other, specify details	_____	
			100%	

5. What is your age? _____ years old

6. What is your gender?

1. ☐ Female
2. ☐ Male

7. What is the highest level of education you have completed? **(Check ONE that applies)** If you completed your education outside Canada, check the closest ONE that applies.

1. ☐ Less than high school (Grade 9 or less)
2. ☐ Some high school (Grade 10 or 11)
3. ☐ Completed high school
4. ☐ Some community/technical college
5. ☐ Completed community/technical college
6. ☐ Some university
7. ☐ Completed university
8. ☐ Other, please give details _____

8. Is speaking English comfortable for you?

1. ☐ Yes
2. ☐ Somewhat
3. ☐ No → What language is most comfortable? _____

Workplace Wellness

The following questions ask about health and wellness at work. Please check your answer ☒ or write your answer in the spaces provided.

9. What information and support would you like to receive or find helpful in your workplace to help people make healthier choices? (*Check TWO options only and rank importance, 1= most important; 2= second most important*)

1. ☐ _____ quit smoking
2. ☐ _____ physical activity
3. ☐ _____ healthy eating/ nutrition
4. ☐ _____ stress
5. ☐ _____ commuting to work
6. ☐ _____ Other, please specify: _____

10. What is the best way to hear about wellness information and support (e.g., physical activity, quit smoking) at your workplace? (**Check all that apply**)

1. ☐ Bulletin board
2. ☐ Supervisor/manager
3. ☐ Posters (for example: cafeteria walls, washroom)
4. ☐ Paystub attachment
5. ☐ Newsletter
6. ☐ Email
7. ☐ Website
8. ☐ Intranet
9. ☐ Other, please give details _____

11. What might stop you from participating in a wellness program offered through your workplace? (**Please check UP TO three reasons**)

1. ☐ Not enough prizes
2. ☐ Cost
3. ☐ Work schedule, please give details _____
4. ☐ Family is not able to participate
5. ☐ Inconvenient location
6. ☐ Lack of transportation
7. ☐ Lack of childcare
8. ☐ Lack of time
9. ☐ Motivation
10. ☐ Nothing
11. ☐ Other, please give details _____

Smoking Behaviour

The following questions ask about cigarette smoking. We want information from people that consider themselves non-smokers as well as from smokers. Please check your answer ☒ or write your answer in the spaces provided.

12. What are the rules about smoking in your home?

1. ☐ No one is allowed to smoke in my home
2. ☐ Only special guests are allowed to smoke in my home
3. ☐ People are allowed to smoke only in certain areas in my home
4. ☐ People are allowed to smoke anywhere in my home

13. At the present time, how frequently do you smoke cigarettes? (**Check ONE that applies**)

1. ☐ Daily
2. ☐ Occasionally (less than 7 days/week or less than 1 cigarette/day)
3. ☐ Not at all

14. Have you smoked at least 100 cigarettes in your life? This is approximately 4-5 packs of cigarettes.

1. ☐ No → you have completed the survey. THANK YOU.
2. ☐ Yes → CONTINUE to next question.

(Non-smokers stop HERE)

15. How many cigarettes do you currently smoke per day on the days that you smoke?

→ Number smoked each day (please specify): _____

16. How soon after you wake up do you smoke your first cigarette?

1. ☐ Within 5 minutes
2. ☐ 6 to 30 minutes
3. ☐ 31 to 60 minutes
4. ☐ More than 60 minutes

17. Are you planning to quit smoking? (**Check ONE that applies**):

1. ☐ Yes, in the next month
2. ☐ Yes, in the next 6 months
3. ☐ Sometime in the future beyond 6 months
4. ☐ I am not planning to quit

20. What type of support would you be interested in having available through work? (**Check ALL that apply**):

1. ☐ Self-help materials (e.g. brochures)
2. ☐ Quit smoking website
3. ☐ Information sessions
4. ☐ Telephone counselling (e.g. Smokers' Helpline)
5. ☐ Contests/challenges to quit smoking
6. ☐ Group support
7. ☐ One-on-one support
8. ☐ Advice from a health professional (e.g. nurse, doctor, dentist, pharmacist)
9. ☐ Nicotine Replacement Therapy (NRT) (e.g. patch, gum)
10. ☐ Quit smoking medications (e.g. Zyban, Champix)
11. ☐ Smoke-free workplace policies (e.g., smoke-free grounds, eliminate smoking from doorways / entrances/ windows). Please specify _____
12. ☐ Other (please specify) _____
13. ☐ None. Why not? _____

21. In the past 6 months, have you ever stopped smoking for one day or longer because you were trying to quit?

1. ☐ No
2. ☐ Yes

22. How likely are you to participate in a quit smoking program if it was offered through your workplace? (**Please check ONE that applies**)

1. ☐ Very unlikely
2. ☐ Unlikely
3. ☐ Likely
4. ☐ Very Likely
5. ☐ Not sure

Other comments?

Thank you for your participation!

You have completed the survey. Thank you for participating in this survey.