

SUPPLEMENTARY MATERIAL

Rock LD, Madathil S, Khanna M, Macdonald LK, Quiñonez C, Glogauer M, Allison P. COVID-19 incidence and vaccination rates among Canadian dental hygienists. *Can J Dent Hyg.* 2022;56(3):123–30.

S1: Questionnaires

Baseline Questionnaire

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Section 1: Contact Information

The contact information you provide, on this page, will be kept confidential and will only be used for the purpose of communicating matters pertinent to this study.

1. Please enter your contact information*

Please write your answer(s) here:

First name: _____

Second name / Surname: _____

Email: _____

Phone: _____

Please **do not** use country code or leave spaces for your phone number.

Example: **5141238888**

Section 2: Demographics & Comorbidity

2. How old are you: *

Your answer must be between 18 and 99. Only an integer value may be entered in this field.

Please write your answer here: _____ years

3. Sex: *

Choose one of the following answers

Please choose **only one** of the following:

- Female
- Male

4. Gender

Check all that apply

Please choose **all** that apply:

- Agender
- Genderqueer
- Gender fluid
- Man
- Non-binary
- Questioning or unsure
- Transgender
- Trans man

- Trans woman
- Woman
- Prefer not to disclose
- Other: _____

5. Please indicate below which group best describes you: *

Choose one of the following answers
Please choose **only one** of the following:

- White (Caucasian)
- South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- Chinese
- Black
- Filipino
- Latin American
- Arab
- Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai, etc.)
- West Asian (e.g., Iranian, Afghan, etc.)
- Korean
- Japanese
- Aboriginal
- Other

6. Smoker

Please choose **only one** of the following:

- Yes
- No

7. Have you ever had following disease(s)/condition(s)?*

Please choose the appropriate response for each item: (Yes/No/Unknown):

	Yes	No	Unknown
Obesity			
Cancer			
Diabetes			
HIV/other immune deficiency			
Asthma (requiring medication)			
Chronic lung disease (non-asthma)			
Chronic liver disease			
Chronic haematological disorder			
Chronic kidney disease			
Chronic neurological impairment/disease			
Organ or bone marrow replacement			
Heart condition			

8. Any other comorbidity:

Please write your answer here: _____

9. Are you currently pregnant?*

Please choose **only one** of the following:

- Yes
- No
- Unknown

10. Specify trimester:

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 10 (Are you currently pregnant?)

Please choose **only one** of the following:

- First trimester
- Second trimester
- Third trimester

11. What is the estimated delivery date?

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 10 (Are you currently pregnant?)

Answer must be greater or equal to today

Please enter a date:

Section 3: Professional Information

12. Please indicate the province where your primary practice, as a dentist or a dental hygienist, is located:

*(office at which you work the most during a week) **

Please choose **only one** of the following:

- Alberta
- British Columbia
- Manitoba
- New Brunswick
- Newfoundland and Labrador
- Nova Scotia
- Ontario
- Prince Edward Island
- Quebec
- Saskatchewan
- Northwest Territories
- Nunavut
- Yukon

13. Please indicate the postal code of your primary practice as a dentist or a dental hygienist (office at which you work the most during a week): *

Please enter a valid postal code (e.g., A1F3Y7)

Please write your answer here:

14. In your primary practice as a dentist or a dental hygienist, are you largely serving a:

Choose one of the following answers

Please choose **only one** of the following:

- Metropolitan community
- Urban community
- Suburban community
- Rural community
- Remote community

15. How many offices do you work in each week?

Please choose **only one** of the following:

- One per week
- Two per week
- Three per week
- More than three per week

16. Are you a dentist or a dental hygienist?*

Please choose **only one** of the following:

- Dentist—General practitioner
- Dentist—Speciality practitioner
- Dental Hygienist
- I have retired from clinical practice since: _____ (Date)

17. Please specify your speciality*

Only answer this question if the following conditions are met:

Answer was 'Dentist—Specialist practitioner' at question 16

Please choose **all** that apply:

- Dental Public Health
- Endodontics
- Oral and Maxillofacial Surgery
- Pediatric Dentistry
- Oral Medicine and Pathology
- Periodontics
- Oral and Maxillofacial Radiology
- Prosthodontics
- Orthodontics and Dentofacial Orthopedics
- Other: _____

18. Please specify your practice type as a dental hygienist.

- Clinical Dental Hygienist (*Working alongside a dentist in private or public sectors*)
- Independent Dental Hygienist (*Working independently or along with other dental hygienists, but not with a dentist, in private or public sectors*)
- Other: _____

19. Is the clinic where you provided care most of the time over the past 2 weeks: *

Please choose **only one** of the following:

- Open [no walls between dental chairs]
- Semi-open [some areas are open to each other while others have walls or other barriers separating them]
- Closed concept [all areas are separated by walls]
- Other

Section 4: Potential for Exposure

20. Have you travelled outside Canada, or have you returned to Canada, in the past 28 days? *

Please choose **only one** of the following:

- Yes
- No

21. In past 28 days, have you travelled within or outside your province or region of residence?

- Yes
- No

22. If yes, please specify the following:

- Travelled only within the region of my current residence
- Travelled outside the region, but within the province of my current residence
- Travelled outside the province of my current residence

23. Have you shared a living space with someone (family or other), in past 28 days?*

Please choose **only one** of the following:

- Yes
- No

24. Did any of your co-habitants attend primary or secondary school in-person, in the past 28 days?

- Yes
- No

25. Did any of your co-habitants attend a day care in-person during the past 28 days?

- Yes
- No

26. Has anyone whom you are living with had a positive test for COVID-19, in the past 28 days?*

Please choose **only one** of the following:

- Yes
- No
- Unknown

27. Has anyone whom you are living with had any symptoms that made you suspect they have COVID-19, in the past 28 days?*

Please choose **only one** of the following:

- Yes
- No
- Unknown

28. In past 28 days, have you attended a health care facility (other than the clinics you provide care) for yourself or a companion?

- Yes
- No

29. In past 28 days, have you attended any private gatherings with persons outside your household?

- Yes
- No

30. In past 28 days, have you attended any public gatherings/events with 50 or more people?

- Yes
- No

31. Have you ever worked at a facility which cares for COVID-19 patients?*

Please choose **only one** of the following:

- Yes
- No

32. Have you ever provided any form of dental care for patients with COVID-19?*

Choose one of the following answers

Please choose **only one** of the following:

- Yes
- No
- Unknown

Section 5: COVID-19 Tests and Symptoms

33. Have you been tested for COVID-19, other than this project since the last follow-up survey?

- Yes
- No

34. Please specify the type of test:

- Nasopharyngeal swab sample and PCR based test
- Nasopharyngeal swab sample and antigen test
- Saliva sample (Other than the test performed in this project) and PCR based Test
- Saliva sample (Other than the test performed in this project) and antigen Test
- Serum sample (Blood) and antibody testing
- Other: _____

35. Date of testing: _____

36. Were you tested positive for SARS-COV2 or COVID-19 in this test?

- Yes
- No
- Inconclusive
- Still waiting for the results

37. Did you ever test positive for COVID-19?*

Please choose **only one** of the following:

- Yes
- No

38. If yes, date of testing: *

Answer must be less or equal to 'today'

Please enter a date:

39. Have you experienced any respiratory symptoms (e.g., sore throat, cough, running nose, shortness of breath) of COVID-19, in last 28 days?*

Please choose **only one** of the following:

- Yes
- No

40. Date of first symptom onset:

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 39 (Have you experienced any respiratory symptoms [e.g., sore throat, cough, running nose, shortness of breath] of COVID-19?)

Answer must be less or equal to 'today'

Please enter a date:

41. Fever (≥ 38 °C) or history of fever*

Choose one of the following answers

Please choose **only one** of the following:

- Yes
- No
- Unknown

42. Date of onset of fever:

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 41 (Fever (≥ 38 °C) or history of fever)

Answer must be less or equal to 'today'

Please enter a date:

43. Sore throat*

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 39 (Have you experienced any respiratory symptoms [e.g., sore throat, cough, running nose, shortness of breath] of COVID-19?)

Choose one of the following answers

Please choose **only one** of the following:

- Yes
- No
- Unknown

44. Date of onset of sore throat:

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 43 (Sore throat)

Answer must be less or equal to 'today'

Please enter a date:

45. Cough*

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 39 (Have you experienced any respiratory symptoms [e.g., sore throat, cough, running nose, shortness of breath] of COVID-19?)

Choose one of the following answers

Please choose **only one** of the following:

- Yes
- No
- Unknown

46. Date of onset of cough:

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 45 (Cough)

Answer must be less or equal to 'today'

Please enter a date:

47. Runny nose*

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 40 (Have you experienced any respiratory symptoms [e.g., sore throat, cough, running nose, shortness of breath] of COVID-19?)

Choose one of the following answers

Please choose **only one** of the following:

- Yes
- No
- Unknown

48. Date of onset of runny nose:

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 47 (Runny nose)

Answer must be less or equal to 'today'

Please enter a date:

49. Shortness of breath*

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 39 (Have you experienced any respiratory symptoms [e.g., sore throat, cough, running nose, shortness of breath] of COVID-19?)

Choose one of the following answers

Please choose **only one** of the following:

- Yes
- No
- Unknown

50. Date of onset of shortness of breath:

Only answer this question if the following conditions are met:

Answer was 'Yes' at question 49 (Shortness of breath)

Answer must be less or equal to 'today'

Please enter a date:

51. Other symptoms*

Please choose the appropriate response for each item:

	Yes	No	Unknown
Chills			
Vomiting			
Nausea			
Diarrhoea			
Headache			
Rash			
Conjunctivitis			

Muscle aches			
Joint aches			
Nosebleed			
Fatigue			
General malaise			
Loss of appetite			
Loss of smell / altered sense of smell			
Loss of taste / altered sense of taste			

52. Any other symptoms*

Choose one of the following answers

Please choose **only one** of the following:

- Yes (Please specify below)
- No
- Unknown

Make a comment on your choice here:

53. Have you stopped working/practicing (even temporarily), in the past 28 days?*

Please choose **only one** of the following:

- Yes
- No

54. Please specify your last date of working/practicing: *

Answer must be less or equal to 'today'

Please enter a date:

Section 6: Activities

These questions are about your clinical activities in the 2 weeks prior to your last working day, or of 2 weeks prior to your COVID-19 positive test; depending on the answer to questions in the previous section.

55. During this period, did you spend most of your time at home?*

Please choose **only one** of the following:

- Yes
- No

56. During this period, how many times did you leave your home?

Please choose **only one** of the following:

- Never
- Once
- Twice
- 3 to 5 times
- 6 to 10 times
- More than 10 times

57. Please choose the outdoor activities you engaged in during this period:

(Choose all that apply)

- Shopping (Including shopping for groceries)
- Physical activity in groups (e.g., Gym, sports, dancing)
- Wellness or lifestyle services (e.g., Spa, Hair or Nail Saloons)
- Accompanying family members to events or appointments
- Visiting family or friends in residence or long-term care facilities
- Other: _____

58. During this period did you provide any form of in-person dental care (including consultations)?*

Please choose **only one** of the following:

- Yes
- No

Section 7: In-person dental care episodes

This section refers to the in-person care you provided during the 2 weeks prior to your last working day, or of 2 weeks prior to your COVID-19 positive test; depending on the answer to questions in the previous section.

59. During this period how many patients did you provide some form of in-person dental care per day on average?*

Your answer must be at least 1

Only an integer value may be entered in this field.

Please write your answer here: _____

Please enter an average number.

60. During this period how many patients per day required an aerosol-generating procedure?*

Only an integer value may be entered in this field.

Please write your answer here: _____

Please enter an average number. If none, enter "0".

61. During this period did you provide any in-person dental care for COVID-19 positive patients?*

Please choose **only one** of the following:

- Yes
- No

62. If yes, for how many COVID-19 positive patients? *

Your answer must be at least 1

Only an integer value may be entered in this field.

Please write your answer here: _____

63. During this period did any of the patients you cared for, have any symptoms that made you suspect they are infected with COVID-19?*

Please choose **only one** of the following:

- Yes
- No

64. If yes, how many patients?*

Your answer must be at least 1

Only an integer value may be entered in this field.

Please write your answer here: _____

65. Please specify the types of in-person dental care you provided during this period

Please choose **all** that apply:

- Advice and education only
- Tooth extraction
- Radiographs
- Examination and evaluation
- Scaling with hand instruments
- Scaling with ultrasonic scaler
- Abscess drainage
- Mineralized tissue removal with handpiece
- Adjustment of prosthesis or orthodontic appliance
- Pulp removal
- Provision of a prescription for a painkiller
- Provision of a prescription for an antibiotic
- Provision of a prescription for another medication
- Other: _____

66. Please specify the types of facial protection you used while providing in-person dental care, during this period*

Please choose the appropriate response for each item:

	For all procedures	For AGPs only	For non AGPs only	For none
Routine surgical mask				

N-95 [or higher] mask				
Eye glasses or goggles				
Facial visor				
Other form of hood or complete head coverage				

67. Did you use any other form of facial covering during the provision of in-person care during this period?*

Please choose **only one** of the following:

- No
- Yes (Please specify below)
- Make a comment on your choice here: _____

68. From the list below, please choose the Infection Prevention and Control (IPC) procedures and amenities in-place at the clinic you provided care during this period*

(Choose all that apply)

- Separate entrance and exit doorways
- Screening or interviewing patients before appointment for COVID-19 related symptoms
- Screening or interviewing staff members for COVID-19 related symptoms
- Checking the temperature of the patients using a thermometer before the appointment
- Checking the temperature of the staff members at least once a day using a thermometer
- Insisting or encouraging patients to wear masks or face covering
 - At all times
 - Only in the waiting area
 - Only in areas close to where dental care is provided
- Disinfecting of surfaces frequently touched by patients (e.g., doorknobs, switches)
 - After every patient
 - More than once per day but not after every patient
 - Once a day only
 - Never
- Preprocedural mouthwash rinse
- Installation of special air filtering or purification unit
- Use of extra oral aerosol suction device during procedures
- Installation of physical barriers in areas of frequent staff-patient interaction (e.g., plexiglass frames)
- Plan in place for contact tracing in case of an outbreak at your clinic
- Other: _____

Follow-Up Questionnaires

Sections 5, 6 and 7 from the Baseline Questionnaire above are repeated for the Follow-up Questionnaire. In addition, a section on vaccination status (Section 8) is added.

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Section 8: COVID-19 Vaccine

The following questions are about vaccination against COVID-19

69. Have you been vaccinated against COVID-19?

(Answer 'Yes' if you have received at least one dose of the COVID-19 vaccine.

Note: Certain types of vaccines require more than one dose to protect against COVID-19. You would have been informed at the time of vaccination if you needed a second dose.)

- Yes
- No

70. How many doses of the COVID-19 vaccine have you received so far?

Choose one of the following answers

- One dose
- Two doses
- More than two doses

71. When did you receive your first dose of the COVID-19 vaccine? _____

72. When did you receive your second dose of the COVID-19 vaccine? _____

73. Which vaccine did you receive? (Choose one of the following answers)

Was it:

- Pfizer and BioNTech mRNA vaccine
- Moderna mRNA vaccine
- AstraZeneca Oxford vaccine
- Don't know
- Other: _____