Supplemental Appendix 2. Participant Questionnaire

1. How old are you?: _____ years old

   If you are unsure or prefer not to answer, please indicate by checking this box: ☐

2. How do you identify your gender identity (i.e. woman, man, two-spirit, transsexual,

   etc)?: _____

   If you are unsure or prefer not to answer, please indicate by checking this box: ☐

3. How do you describe your identity? *For example, Caucasian, Canadian, South Asian, First Nations, etc.)*: _____

   If you are unsure or prefer not to answer, please indicate by checking this box: ☐

4. How many years of experience do you have working in obesity treatment?: _____

   _____

5. Approximately how many hours per week are spent in obesity treatment?: _____

   _____

6. How long have you been affiliated with HOPPS?: _____

   _____

7. What type of health care provider are you? Please describe your title and role:

   _____

   _____

8. Did you complete health care provider training (ie: medical school or nursing school) in Canada? If not, where did you complete your provider training?:

   _____

9. What languages do you speak with patients?:

   _____

   _____