Evidence-Based Practice (EBP) II Practice Exam (Sample)

Study Guide

Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- **Practice answering questions under realistic conditions,**
- **Improve accuracy and speed,**
- **Review explanations to strengthen weak areas, and**
- **Approach the exam with greater confidence.**

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here’s how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don’t just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There’s no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

1. **Which measure is commonly used in case-control studies and logistic regression to estimate association between exposure and outcome?**

   A. Relative risk

   B. Odds ratio

   C. Risk difference

   D. Hazard ratio

2. **From a 2x2 contingency table, which pairing gives the number of people with the condition?**

   A. True positive and false negative.

   B. False positive and true negative.

   C. True positive and true negative.

   D. False positive and false negative.

3. **Which criterion is used to assess validity of evidence about prognostic factors to avoid heterogeneity?**

   A. Was the study randomized?

   B. Did all subjects enter at the same stage of their condition?

   C. Were outcomes blinded to prognostic factor status?

   D. Was the sample size adequate?

4. **Documents and artifacts in qualitative research commonly include:**

   A. Medical records, diaries, photos, videos, social media text, historical documents

   B. Blood test results and lab reports

   C. Coded survey responses with numerical scales

   D. Wearable device data and sensor logs

5. **Which nonparametric test is used for two related samples (paired data)?**

   A. Sign test

   B. McNemar test

   C. Paired t-test

   D. Wilcoxon signed-ranks test

6. Which statement correctly describes how prevalence affects PPV?

A. PPV is independent of prevalence.

B. PPV rises when prevalence is high; falls when prevalence is low.

C. PPV equals sensitivity.

D. PPV equals NPV.

7. Which statement defines intra-rater reliability?

A. Two raters independently assess the same patient

B. The same rater tests the same patient on different occasions

C. Different tests are used to measure the same construct

D. The same rater tests the same patient on different conditions

8. Member checking definition?

A. After analysis, summarize results for publication

B. After analysis, researchers return findings to participants to verify accuracy

C. Data triangulation across sources

D. Audit trail documentation

9. Which scale has equal intervals between values but no true zero, allowing addition and subtraction?

A. Ordinal

B. Interval

C. Ratio

D. Nominal

10. Sensitivity is best described as:

A. How well does the test detect true cases (focuses on true positives).

B. How well does the test exclude non-cases (true negatives).

C. The proportion of all results that are true positives.

D. The proportion of true negatives among those without the disease.

Answers

1. B
2. A
3. B
4. A
5. D
6. B
7. D
8. B
9. B
10. A

Explanations

1. Which measure is commonly used in case-control studies and logistic regression to estimate association between exposure and outcome?

A. Relative risk

B. Odds ratio

C. Risk difference

D. Hazard ratio

In case-control studies and in logistic regression, the measure used to estimate how strongly exposure is associated with an outcome is the odds ratio. In case-control designs, you start with individuals based on outcome status, so you don't have information to directly compute risk or incidence in the population. Instead, you compare the odds of having been exposed among cases to the odds of exposure among controls. That ratio of odds reflects the strength of the association between exposure and disease. In logistic regression, the model estimates how predictors affect the log odds of the outcome, and exponentiating the coefficients yields odds ratios for a one-unit change in the predictor, making odds ratios the natural effect size to report. When the outcome is rare, the odds ratio closely approximates the relative risk, which is why it's often interpreted in a way similar to risk. The other measures aren't as appropriate here: relative risk requires incidence data, hazard ratio comes from time-to-event analyses, and risk difference is a straight difference in risk rather than a ratio of odds.

2. From a 2x2 contingency table, which pairing gives the number of people with the condition?

A. True positive and false negative.

B. False positive and true negative.

C. True positive and true negative.

D. False positive and false negative.

In a diagnostic 2x2 table, to know how many people actually have the condition, add those who truly have it regardless of their test result. True positives are people who test positive and do have the condition, while false negatives are people who have the condition but test negative. Adding these two groups gives the total number of individuals with the condition. The other pairings don't represent those with the condition: false positives and true negatives are people without the condition, true positives plus true negatives are all correct test outcomes, and false positives plus false negatives are all incorrect test outcomes. So the correct pairing is true positives and false negatives.

3. Which criterion is used to assess validity of evidence about prognostic factors to avoid heterogeneity?

A. Was the study randomized?

B. Did all subjects enter at the same stage of their condition?

C. Were outcomes blinded to prognostic factor status?

D. Was the sample size adequate?

When evaluating evidence about prognostic factors, reducing variation that can blur true associations is essential. If patients are at different stages of their disease, the same prognostic factor can behave differently, making results look inconsistent or non-generalizable. Ensuring that all subjects enter at the same stage of their condition directly limits this heterogeneity, so the observed relationship between the factor and outcomes more faithfully reflects its prognostic value rather than differences in disease progression. Other considerations address different biases or issues but don't tackle this source of heterogeneity. Randomization helps with treatment allocation bias, not stage-related variation in prognosis. Blinding outcome assessment to factor status reduces measurement bias but doesn't harmonize disease stage across participants. Adequate sample size improves precision but doesn't fix stage-related differences that confound prognostic effects.

4. Documents and artifacts in qualitative research commonly include:

A. Medical records, diaries, photos, videos, social media text, historical documents

B. Blood test results and lab reports

C. Coded survey responses with numerical scales

D. Wearable device data and sensor logs

Qualitative research relies on naturally occurring, non-numerical data that reveal people's experiences, meanings, and social processes. Documents and artifacts—such as medical records, diaries, photographs, videos, social media posts, and historical documents—provide rich material for interpretation, allowing researchers to explore narratives, practices, and contexts in depth. These sources are analyzed through methods like thematic coding, content analysis, or discourse analysis to understand how people construct reality and how social phenomena unfold over time. The other data types described are typically quantitative, offering numerical measurements from lab tests, standardized survey scales, or continuous sensor streams. Therefore, documents and artifacts are the hallmark of qualitative data sources.

5. Which nonparametric test is used for two related samples (paired data)?

A. Sign test

B. McNemar test

C. Paired t-test

D. Wilcoxon signed-ranks test

When comparing two related samples, a nonparametric method that handles paired data by using both the direction and the size of the differences is appropriate. The Wilcoxon signed-ranks test does this by taking the differences between each paired observation, ranking the absolute values of those differences, and then summing the ranks for the positive and negative differences. If there is no real change, the positive and negative rank sums should be similar; if there is a genuine median difference, one sign will dominate, leading to a noticeable imbalance in the rank sums. This test does not assume normality and works with ordinal or non-normally distributed continuous data, making it more informative than the sign test because it incorporates the magnitude of differences, not just their direction. In contrast, the paired t-test is a parametric test that assumes the differences are normally distributed, which isn't required for the Wilcoxon approach. The sign test uses only the direction of change and ignores how large the differences are, resulting in less statistical power. The McNemar test is designed for paired binary outcomes in a 2x2 framework and isn't suitable for using magnitude information from non-normal data.

6. Which statement correctly describes how prevalence affects PPV?

A. PPV is independent of prevalence.

B. PPV rises when prevalence is high; falls when prevalence is low.

C. PPV equals sensitivity.

D. PPV equals NPV.

The key idea is that PPV depends on how common the disease is in the population. Positive predictive value is the probability that a person who tests positive actually has the disease. If the test's sensitivity and specificity stay the same, increasing disease prevalence makes a positive result more likely to come from someone with the disease, so PPV goes up. Conversely, when prevalence is low, many positives come from people without the disease, so PPV goes down. A helpful way to see this is the formula: PPV = (sensitivity × prevalence) / [(sensitivity × prevalence) + (1 − specificity) × (1 − prevalence)]. As prevalence increases, the numerator grows relative to the denominator in a way that raises the ratio, and as prevalence decreases, the ratio falls. That's why PPV rises with higher prevalence and falls with lower prevalence. This is why statements claiming PPV is independent of prevalence aren't correct, and why PPV is not equal to sensitivity or to NPV.

7. Which statement defines intra-rater reliability?

A. Two raters independently assess the same patient

B. The same rater tests the same patient on different occasions

C. Different tests are used to measure the same construct

D. The same rater tests the same patient on different conditions

Intra-rater reliability is about the repeatability of a measurement by the same examiner. It asks whether a single rater would obtain the same score when assessing the same patient on different occasions. This is typically evaluated with a test-retest approach: the same rater uses the same instrument on the same patient on separate occasions, and the results are compared (often using statistics like the intraclass correlation coefficient or Cohen's kappa for categorical data). The other ideas describe different concepts: two raters (inter-rater reliability), using different tests for the same construct (validity or measurement equivalence), or a single rater across different conditions (a different form of variability).

8. Member checking definition?

A. After analysis, summarize results for publication

B. After analysis, researchers return findings to participants to verify accuracy

C. Data triangulation across sources

D. Audit trail documentation

Member checking is when, after analyzing data, the researcher returns findings or interpretations to the participants to confirm that the results accurately reflect their experiences and viewpoints. This step helps establish credibility by giving participants a chance to validate, correct, or elaborate on what the researchers identified, reducing misinterpretations and missing details. It can involve sharing a summary of themes, draft interpretations, or even reviewed transcripts and asking for feedback on accuracy and resonance. The correct description aligns with this process of participant verification. Other options describe related but distinct practices: summarizing results for publication refers to dissemination rather than verification; data triangulation across sources means corroborating findings across multiple data sources; an audit trail documents the research process and decisions rather than directly involving participants in confirming findings.

9. Which scale has equal intervals between values but no true zero, allowing addition and subtraction?

A. Ordinal

B. Interval

C. Ratio

D. Nominal

The scale in question is defined by having equal distances between values while lacking a true zero point. That combination means you can reliably measure how far apart two values are and perform addition and subtraction, but you can't meaningfully multiply or form ratios because zero isn't truly zero. A classic example is temperature on the Celsius scale: the difference between 20°C and 30°C is the same as between 80°C and 90°C, so intervals are equal, and you can add or subtract temperatures. But 0°C doesn't mean "no temperature," so you can't say that 60°C is twice as hot as 30°C. Other scales don't fit this description: nominal scales categorize without any order, and ordinal scales provide order but not equal intervals between steps. A ratio scale has a true zero, allowing meaningful ratios and all arithmetic, which is beyond what an interval scale allows.

10. Sensitivity is best described as:

A. How well does the test detect true cases (focuses on true positives).

B. How well does the test exclude non-cases (true negatives).

C. The proportion of all results that are true positives.

D. The proportion of true negatives among those without the disease.

Sensitivity is about catching disease when it's really present. It's the true positive rate—the proportion of actual disease cases that the test correctly identifies as positive. In formula form, sensitivity = true positives / (true positives + false negatives). This means a highly sensitive test minimizes false negatives, so fewer people with the disease are missed. The other descriptions pull in different ideas. Excluding non-cases is about specificity, not sensitivity, and describes how well the test identifies those without the disease. Saying that a large share of all results are true positives mixes in how often the disease occurs and other error types, which isn't what sensitivity measures. So the description focusing on detecting true cases among those who have the disease is the best fit.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://ebp2.examzify.com

We wish you the very best on your exam journey. You've got this!