

IMMUNIZATION SURVEY SPECIAL SWORN STATUS

Instructions: A separate form must be completed by each person who will have access to the data sent by the U.S. Census Bureau and/or who will be completing the data collection forms for the National Immunization Survey.

PART A - PRACTICE/CLINIC/HOSPITAL INFORMATION

1. Practice/Clinic/Hospital name

2. Practice/Clinic/Hospital address

3. Practice/Clinic/Hospital telephone number *(Including area code)*

PART B – CONTACT IDENTIFICATION

Please provide your name and contact information.

1. Name *(Last, First, Middle)*

By checking this box, I agree that I am 18 years old or older

2. Contact telephone number *(Including area code and extension)*

3. Position/Job title

PART C – WAIVER OF COMPENSATION

I, the undersigned, offer my services to the U.S. Census Bureau as Special Sworn staff on a voluntary basis without compensation.

PART D – OATH OF NONDISCLOSURE

By signing below, I, _____, certify, under penalty of perjury, that I will keep the identity of any patients related to this survey confidential. I will not disclose information that might identify a person in the National Immunization Survey Evaluation Study to any person other than those with Census Bureau Special Sworn Status and direct involvement in this study. I also understand that under Title 13, U.S.C. section 214 and Title 18, U.S.C.3551, et. seq., the penalty for unlawful disclosure is a fine of not more than \$250,000 or imprisonment for not more than 5 years, or both.

(Signature of appointee)

(Date)



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