NHSN Registration Form

OMB No. xxxx-xxxx
Exp. Date: xx-xx-20xx

Personal Information

*Last Name:_____ *First Name: _____

Middle Name:_____

*Email address: _____

Facility Identifier

*Please select a facility identifier:

☐ CMS ID ☐ AHA ID ☐ VA Station Code

☐ CDC Registration ID ☐ None

*Selected identifier ID: _____

NHSN Training Date:

*I certify that I have completed all of the appropriate, required NHSN trainings on: ___/___/_____

mm dd yyyy

Assurance of Confidentiality: The information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average less than 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-79, Atlanta, GA 30333, ATTN: PRA (0920-0666).