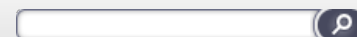




Indian Health Service

The Federal Health Program for American Indians and Alaska Natives

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Step 1 - Best and Promising Practice and Local Effort Electronic Submission Form

FORM APPROVED
OMB Approval No. 0917-0034
Exp. Date 11/30/2011

[Exit this form](#)

To submit a best practice, promising practice, local effort, resource, or policy, please complete the inventory form below. Your submission will not be saved until the final step and you will be prompted to complete all required fields. At the end of the form, you will have an opportunity to preview and edit your submission before sending it to the database.

* Indicates a Required Field

* 1. Please provide the name, title and contact information for the person filling in this template.

Name: *

Site or location name: *

Address 1: *

Address 2:

City/Town: *

State: * -- select state --

ZIP: *

Country:

Email Address: *

Phone Number: *

* 2. Should people reviewing your submission contact someone other than yourself for questions about the program?

Yes
No

By submitting this form you are agreeing that you or your designee can be contacted regarding this submission.

Public Burden Statement: In accordance with Paperwork Reduction Act (5 CFR 1320.8 (b)(3)), a Federal 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. Respondents must be informed (on the reporting instrument, in instructions, or in a cover letter) the reasons for which the information will be collected; the way the information will be used to further the proper performance of the functions of the agency; whether responses to the collection of the information are voluntary, required to obtain a benefit (citing authority), or mandatory (citing authority); and the nature and extent of confidentiality to be provided, if any (citing authority). Public reporting burden for this collection of information is estimated to average 20 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the necessary data, and completing and reviewing the collection information. Send comments regarding the burden estimate or any other aspect of this collection of information to the IHS PRA Information Collection Clearance Staff, 801 Thompson Ave., Suite 450, Rockville, MD 20852.



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Step 2 - Best and Promising Practice and Local Effort Electronic Submission Form

* Indicates a Required Field

[Exit this form](#)

* 3. Please provide the contact information of the person the reviewer should contact:

Name: * (Required only if answer to Question 2 is yes)

Site or location name:

Address:

Address 2:

City/Town:

State:

ZIP/Postal Code:

Country:

Email Address: * (Required only if answer to Question 2 is yes)

Phone Number: * (Required only if answer to Question 2 is yes)

* 4. What type of program or information are you submitting?

- Evidence Based Practice:** Programs formally evaluated to be effective, or Best Practices, that can be replicated and implemented, even with modifications in other settings
- Promising Practice:** Programs not formally evaluated (or formal evaluation is not yet complete) but identified by experts as programs with results suggesting efficacy and worthy of further study in broader pilot implementation efforts.
- Local Effort:** Programs and/or activities that have not been evaluated but are identified by local programs as producing positive results.
- Resources:** Information or materials that might help develop a program/project in a community but can not be defined as a Best Practice, Promising Practice, or Local Effort.
- Policy:** An ordinance, resolution, or law passed by a community that produces positive results.



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Step 3 - Best and Promising Practice and Local Effort Electronic Submission Form

* Indicates a Required Field [Exit this form](#)

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***4. Please choose the service area, from the drop down list below, that best describes the location of the program or information you are submitting. A map of the 12 IHS service areas is below to help you with your selection.**

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--- Select Service Area ---

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*** 5. What is the Title of the program or information being entered?**

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*** 6. Please define the project's target population: (check all that apply)**

- Infants (0-12 months)
- Children (2-11 years)
- Adults (18-64 years)
- Toddler (12-24 months)
- Adolescent (12-17 years)
- Elderly (65+ years)

*** 7. Please describe the type of location where the project takes place: (check all that apply)**

- Community
- Hospital
- School
- Clinic/Health Center
- Home
- Work site
- Other (please specify)

*** 8. Please check the targeted health indicators impacted by the project. (Check all that Apply)**

Note: Review of content is based partially on the Health Indicator(s) selected. Selecting more than one Indicator might require additional review, result in delay of approval, and publication of your submission for one Indicator before others.

- Cardiovascular Disease
- Child Abuse/Neglect
- Diabetes
- Domestic Violence
- Environmental Quality
- Excessive Alcohol Consumption
- Health Education
- Healthcare Access
- Immunization
- Infectious Disease
- Information Technology
- Injury and Violence
- Maternal Child Health
- Mental Health
- Methamphetamines
- Oral Health
- Overweight and Obesity
- Pets/Animals
- Physical Activity
- Substance Abuse
- Tobacco Use
- Traditional Healing

9. Please describe the project that you are submitting.

B I [List Bullets] [List Numbered]

10. Please list the website where information about the program can be found (if applicable):

11. Please select at least one key word that would describe the project you are submitting. (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Advocacy | <input type="checkbox"/> Lifestyle coaching |
| <input type="checkbox"/> Alcohol/substance abuse prevention | <input type="checkbox"/> Motivation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Behavioral health/behavioral change | <input type="checkbox"/> Physical activity |
| <input type="checkbox"/> Breastfeeding | <input type="checkbox"/> Pregnancy prevention |
| <input type="checkbox"/> Capacity building or empowerment | <input type="checkbox"/> Public Health intervention |
| <input type="checkbox"/> Child abuse prevention | <input type="checkbox"/> School health |
| <input type="checkbox"/> Chronic conditions | <input type="checkbox"/> Scientific research |
| <input type="checkbox"/> Community assessment | <input type="checkbox"/> Staff qualification or credentials |
| <input type="checkbox"/> Community directed intervention | <input type="checkbox"/> Sudden Infant Death Syndrome |
| <input type="checkbox"/> Community mobilization/organization | <input type="checkbox"/> Suicide prevention |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Surveillance |
| <input type="checkbox"/> Disability prevention | <input type="checkbox"/> Teaching strategies |
| <input type="checkbox"/> Domestic violence prevention | <input type="checkbox"/> Tobacco cessation |
| <input type="checkbox"/> Drug abuse prevention | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Environmental change | <input type="checkbox"/> Unintentional injury |
| <input type="checkbox"/> Group process | <input type="checkbox"/> Violence and Intentional injury |
| <input type="checkbox"/> Health literacy | <input type="checkbox"/> Worksite health |
| <input type="checkbox"/> Health promotion and wellness | <input type="checkbox"/> Zoonotic Disease (has an animal link) |
| <input type="checkbox"/> HIV prevention | <input type="checkbox"/> Other(please specify) |
| <input type="checkbox"/> Interview and teaching strategies | <input type="text"/> |

Questions 12 to 13 are required in order to be considered evidence based practice or submission will be considered a promising practice or local effort upon evaluation unless materials are available for review.

*** 12. Was the project evaluated?**

- Yes
- No

*** 13. Is the evaluation summary available?**

- Yes
- No

*** 14. Please specify a file or a set of files:**

Accepted file types are: .doc, .pdf, .txt, .rtf

* If you are not able to upload your documents, or your documents are larger than 5 MB in size, you may send the evaluation materials one of the following ways:

Mail Address:
Indian Health Service
Attn: OSCAR Team
801 Thompson Ave, Suite 300
Rockville, MD 20852

Fax: (301)594-6213, or (301) 443-7623
Attn: OSCAR Team

15. What is/was the overall cost (estimate) of the program?

16. Any final comments?

