**This exception must be renewed at least annually**

Specify the calendar year, applicable quarter(s), and location for the specific National Healthcare Safety Network (NHSN) HAI Measure exception request(s). Please use this form to indicate that your facility does not have one or more of the location(s) provided below for the respective quarter.

\* Indicates required fields

**\*HAI Measure Exception Information** (The exception(s) you are requesting must be selected)

**Select all that apply**

**Catheter-Associated Urinary Tract Infection (CAUTI)**   
 Hospital does not have the location(s) as indicated below.

Calendar Year (YYYY)\_\_\_\_\_\_\_\_\_\_\_\_\_

January 1 through March 31 April 1 through June 30

July 1 through September 30 October 1 through December 31

**\*I have reviewed NHSN definitions for (select all that apply):**

ICU locations

Oncology Medical ICU Oncology Med/Surg ICU

Oncology Surg ICU Oncology Pediatric ICU

Non-ICU locations

Step Down Unit Solid Tumor Ward

Leukemia Ward Hematopoietic Stem Cell Transplant Ward

Leukemia/Lymphoma Ward General Hematology/Oncology Ward

Lymphoma Ward Pediatric Hematopoietic Stem Cell Transplant Ward

Pediatric general Hematology/Oncology Ward

**Central Line-Associated Bloodstream Infection (CLABSI)**   
 Hospital does not have the location(s) as indicated below.

Calendar Year (YYYY)\_\_\_\_\_\_\_\_\_\_\_\_\_

January 1 through March 31 April 1 through June 30

July 1 through September 30 October 1 through December 31

**\*I have reviewed NHSN definitions for (select all that apply):**

ICU locations

Oncology Medical ICU Oncology Med/Surg ICU

Oncology Surg ICU Oncology Pediatric ICU

Non-ICU locations

Step Down Unit Solid Tumor Ward

Leukemia Ward Hematopoietic Stem Cell Transplant Ward

Leukemia/Lymphoma Ward General Hematology/Oncology Ward

Lymphoma Ward Pediatric Hematopoietic Stem Cell Transplant Ward

Pediatric general Hematology/Oncology Ward

**Facility Contact Information**

\*CMS Certification Number (CCN):

\*Facility Name:

\*CEO/Designee Last Name:

\*CEO/Designee First Name:

\*Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*CEO/Designee E-Mail Address:

\*CEO/Designee Telephone Number: \_\_\_-\_\_\_-\_\_\_\_ ext. \_\_\_\_\_\_\_\_\_\_

Additional Comments:

I hereby certify that the facility meets the exception criteria and therefore has no data to submit for the specified location(s) related to the specified HAI measure(s)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRA Disclosure Statement  
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