Form Approved
OMB No. 0920-0666
Exp. Date: xx/xx/20xx
www.cdc.gov/nhsn

Facility Contact Information

*required for saving	Tracking #:

*Facility Name:

*Main Telephone Number:

*Mailing Address: _____

_____

_____

*City: *County: *State: *ZIP: -

For each identifier listed below, enter the # / code or check "Not Applicable" if your facility does not have that identifier:

*American Hospital Association ID#: ☐ Not Applicable

*CMS Certification Number (CCN): ☐ Not Applicable

*VA Station Code: ☐ Not Applicable

If none of the above identifiers is applicable, enter CDC-provided Enrollment #:

***Facility Type:**

*Was this facility operational in the survey year? ☐ Yes ☐ No

***NHSN Components:**
Indicate which component(s) the Facility will use initially:
(Components are available only to specific NHSN facility types. Please see NHSN enrollment guidance and surveillance protocols to determine which component(s) your facility should use within NHSN. Components may be added at any time after enrollment.)

☐ Patient Safety Component	☐ Dialysis Component
☐ Healthcare Personnel Safety Component	☐ Long Term Care Facility Component
☐ Biovigilance Component	☐ Outpatient Procedure Component

NHSN Facility Administrator:

*Name:

Title:

*Mailing address: (if different from facility)

_____

_____

_____

*City:	*State:	*ZIP: -
*Telephone Number: ( )	Extension:	

FAX Number: ( )

Pager Number: ( )

*Email: *User Name:

Assurance of Confidentiality: The voluntarily provided 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 10 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-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).

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Facility Contact Information

Patient Safety Primary Contact Person (if different from Facility Administrator)		
*Name:		
Title:		
*Mailing address: (if different from facility) _____ _____ _____		
*City:	*State:	*ZIP: -
*Telephone Number: ( )	Extension:	FAX Number: ( )
Pager Number: ( )	*Email:	*Valid email account required for enrollment*

Dialysis Facility Primary Contact Person (if different from Facility Administrator)		
*Name:		
Title:		
*Mailing address: (if different from facility) _____ _____ _____		
*City:	*State:	*ZIP: -
*Telephone Number: ( )	Extension:	FAX Number: ( )
Pager Number: ( )	*Email:	*Valid email account required for enrollment*

Long Term Care Facility Primary Contact Person (if different from Facility Administrator)		
*Name:		
Title:		
*Mailing address: (if different from facility) _____ _____ _____		
*City:	*State:	*ZIP: -
*Telephone Number: ( )	Extension:	FAX Number: ( )
Pager Number: ( )	*Email:	*Valid email account required for enrollment*

Healthcare Personnel Safety Primary Contact Person (if different from Facility Administrator)		
*Name:		
Title:		
*Mailing address: (if different from facility) _____ _____ _____		
*City:	*State:	*ZIP: -
*Telephone Number: ( )	Extension:	FAX Number: ( )
Pager Number: ( )	*Email:	*Valid email account required for enrollment*

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Facility Contact Information

Biovigilance Primary Contact (if different from Facility Administrator)		
*Name:		
Title:		
*Mailing address: (if different from facility) _____ _____ _____		
*City:	*State:	*ZIP: -
*Telephone Number: ( )	Extension:	FAX Number: ( )
Pager Number: ( )	*Email:	*Valid email account required for enrollment*

†**Microbiology Laboratory Director/Supervisor (if different from Facility Administrator)** †Optional for Dialysis Facilities		
*Name:		
Title:		
*Mailing address: (if different from facility) _____ _____ _____		
*City:	*State:	*ZIP: -
*Telephone Number: ( )	Extension:	FAX Number: ( )
Pager Number: ( )	*Email:	*Valid email account required for enrollment*

Outpatient Procedure Primary Contact (if different from Facility Administrator)		
*Name:		
Title:		
*Mailing address: (if different from facility) _____ _____ _____		
*City:	*State:	*ZIP: -
*Telephone Number: ( )	Extension:	FAX Number: ( )
Pager Number: ( )	*Email:	*Valid email account required for enrollment*