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| **Pharmacy Registration Page** | | |
| \*Email: | | \* |
| \*Organization Name: | | \* |
| \*First Name: | | \* |
| \*Last Name: | | \* |
| Title/Position: | |  |
| \*Address 1: | | \* |
| Address 2: | |  |
| \*City: | | \* |
| \*State: | | \* |
| \*Zip Code: | | \* \* |
| |  |  | | --- | --- | | \*Telephone number: | ( )\* \* \* \* - \* \* Ext.: \* |   Fax number: ( ) \* \* - \* | | |
| \* 1. Which of the following do you represent? | | | |
|  | |  | | --- | | Pharmacy/Pharmacy System | | Quality Improvement Organization (QIO) | | An organization or vendor submitting data on behalf of a pharmacy or pharmacy system | | Another type of organization (please specify) |   \* | | |
| \* 2. Will you have completed survey data collection and be able to submit your final electronic data file by November 1, 2014? | | | |
|  | |  |  | | --- | --- | | Yes No | | |  | | | |
| \* 3. How many pharmacies will you be submitting for? \* | | | |
| \* 4. Did you make any changes to the AHRQ Pharmacy SOPS Questionnaire? | | | |
|  | |  | | --- | | Yes | | No | | | |

