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| **Pharmacy Registration Page** |
| \*Email:  | \*  |
| \*Organization Name:  | \*  |
| \*First Name:  | \*  |
| \*Last Name:  | \*  |
| Title/Position:  |  |
| \*Address 1:  | \*  |
| Address 2:  |  |
| \*City:  | \*  |
| \*State:  | \*  |
| \*Zip Code:  | \* \*  |
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| --- | --- |
| \*Telephone number:  | ( )\* \* \* \* - \* \* Ext.: \*  |

 Fax number: ( ) \* \* - \*  |
| \* 1. Which of the following do you represent?  |
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| 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?  |
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| Yes No |
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| \* 3. How many pharmacies will you be submitting for? \* |
| \* 4. Did you make any changes to the AHRQ Pharmacy SOPS Questionnaire?  |
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| Yes |
| No |

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