ATTACHMENT A

Pharmacy Registration Page

*Email: [ ] *

*Organization Name: [ ]

*First Name: [ ]

*Last Name: [ ]

Title/Position: [ ]

*Address 1: [ ]

Address 2: [ ]

*City: [ ] *

*State: --Select a 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? [1]

* 4. Did you make any changes to the AHRQ Pharmacy SOPS Questionnaire?

( ) Yes

ATTACHMENT A

No

Save