Attachment D3

National Health and Nutrition Examination Survey (NHANES)
Vaccination Provider Record Check Pilot
Provider Form

OMB no. 0920-0950
Expires: 11/30/2016

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

Public reporting burden of this collection of information is estimated to average 15 minutes per response for NHANES participants, 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/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-74, Atlanta, GA 30333. ATTN: PRA (0920-0950).

NEW1 Which of the following best describes your immunization records for this individual?

YOU HAVE ALL OR PARTIAL IMMUNIZATION RECORDS FOR THIS INDIVIDUAL FOR VACCINES GIVEN BY YOUR PRACTICE OR OTHER PRACTICES..... 1 (NEW2)

YOU HAVE PROVIDED CARE TO THIS INDIVIDUAL, BUT DO NOT HAVE IMMUNIZATION RECORDS 2 (NEW21)

YOU HAVE NO RECORD OF PROVIDING CARE TO THIS INDIVIDUAL..... 3 (NEW21)

NEW2 Was any of the immunization information for this individual obtained from your community or state registry?

YES..... 1
NO 2
DON'T KNOW 3

NEW3 According to your records, what is this individual's date of birth?

_____
ENTER BIRTHDATE (MM/DD/YYYY)

DON'T KNOW 999

NEW4 What was the date of this individual's first visit, for any reason, to this place of practice?

_____
ENTER DATE (MM/DD/YYYY)

DON'T KNOW 999

NEW5 What was the date of this individual's most recent visit, for any reason, to this place of practice?

_____
ENTER DATE (MM/DD/YYYY)

DON'T KNOW 999

NEW6 Enter date of the Tdap vaccine received at age 11 years or older

_____
ENTER DATE (MM/DD/YYYY)

NEW7 Was this Tdap vaccine given by another practice?

YES..... 1
NO 2

NEW8 Enter date of the first meningococcal conjugate vaccine (serogroups ACWY: Menactra® or Menveo®)

_____
ENTER DATE (MM/DD/YYYY)

NEW9 Was the first meningococcal conjugate vaccine given by another practice?

YES..... 1
NO 2

NEW10 Enter date of the second meningococcal conjugate vaccine (serogroups ACWY: Menactra® or Menveo®)

_____
ENTER DATE (MM/DD/YYYY)

NEW11 Was the second meningococcal conjugate vaccine given by another practice?

YES..... 1
NO 2

NEW12 Enter date of the first human papillomavirus (HPV) vaccine

_____
ENTER DATE (MM/DD/YYYY)

NEW13 Was the first HPV vaccine given by another practice?

YES..... 1
NO 2

NEW14 Was this vaccine Gardasil® (4vHPV), Gardasil® 9 (9vHPV), or Cervarix® (2vHPV)?

Gardasil® (4vHPV)..... 1
Gardasil® 9 (9vHPV) 2
Cervarix® (2vHPV)..... 3

NEW15 Enter date of the second human papillomavirus (HPV) vaccine

_____
ENTER DATE (MM/DD/YYYY)

NEW16 Was the second HPV vaccine given by another practice?

YES..... 1
NO 2

NEW17 Was this vaccine Gardasil® (4vHPV), Gardasil® 9 (9vHPV), or Cervarix® (2vHPV)?

Gardasil® (4vHPV)..... 1
Gardasil® 9 (9vHPV) 2
Cervarix® (2vHPV)..... 3

NEW18 Enter date of the third human papillomavirus (HPV) vaccine

_____
ENTER DATE (MM/DD/YYYY)

NEW19 Was the third HPV vaccine given by another practice?

YES	1	
NO	2	

NEW20 Was this vaccine Gardasil® (4vHPV), Gardasil® 9 (9vHPV), or Cervarix® (2vHPV)?

Gardasil® (4vHPV)	1	(END)
Gardasil® 9 (9vHPV)	2	(END)
Cervarix® (2vHPV)	3	(END)

NEW21 Which of the following describes this facility?

PRIVATE PRACTICE, SOLO	1
PRIVATE PRACTICE, GROUP	2
PRIVATE PRACTICE, HEALTH MAINTANCE ORGANIZATION (HMO)	3
HOSPITAL-BASED CLINIC, INCLUDING UNIVERSITY CLINIC, OR RESIDENCY TEACHING PRACTICE	4
PUBLIC HEALTH DEPARTMENT-OPERATED CLINIC	5
COMMUNITY HEALTH CENTER	6
RURAL HEALTH CLINIC	7
MIGRANT HEALTH CENTER	8
INDIAN HEALTH SERVICE (IHS)-OPERATED CENTER, TRIBAL HEALTH FACILITY, OR URBAN INDIAN HEALTH CARE FACILITY	9
MILITARY HEALTH CARE FACILITY (ARMY, NAVY, AIR FORCE, MARINES, COASTGUARD)	10
WIC CLINIC	11
SCHOOL BASED HEALTH CENTER	12
PHARMACY	13
NON-MEDICAL FACILITY THAT HOSTED A VACCINATION CLINIC RUN BY THE HEALTH DEPARTMENT OR OTHER SPONSOR	14
OTHER	15

NEW22 Which of the following best describe the main specialties of this facility?
(MAY CHOOSE MORE THAN ONE)

PEDIATRICS	1
FAMILY PRACTICE	2
GENERAL PRACTICE	3
INTERNAL MEDICINE	4
OB/GYN	5
OTHER	6

NEW23 Enter contact name for the person returning this form

_____
ENTER NAME

NEW24 Title for the person returning this form

PHYSICIAN	1
NURSE	2
OFFICE MANAGER/RECEPTIONIST	3
MEDICAL RECORDS ADMINISTRATOR/ TECHNICIAN	4
OTHER	5

NEW25 Enter contact phone number for the person returning this form

_____
ENTER PHONE NUMBER (XXX/XXX/XXXX)

NEW26 Enter contact fax number for the person returning this form

_____
ENTER FAX NUMBER (XXX/XXX/XXXX)