

**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY
EIP HEALTHCARE FACILITY ASSESSMENT—FOR EIPT USE ONLY**

Hospital ID: _____

Survey date: / /

1) Enter the date on which you are completing this form: / /

2) Enter your initials: _____

3) Is the hospital located in an urban or rural area?

- Rural
- Urban
- Unknown

4) Does the hospital have an American Medical Association (AMA)-approved residency program?

- Yes
- No
- Unknown

5) Is the hospital a member of the Council of Teaching Hospitals (COTH)?

- Yes
- No
- Unknown