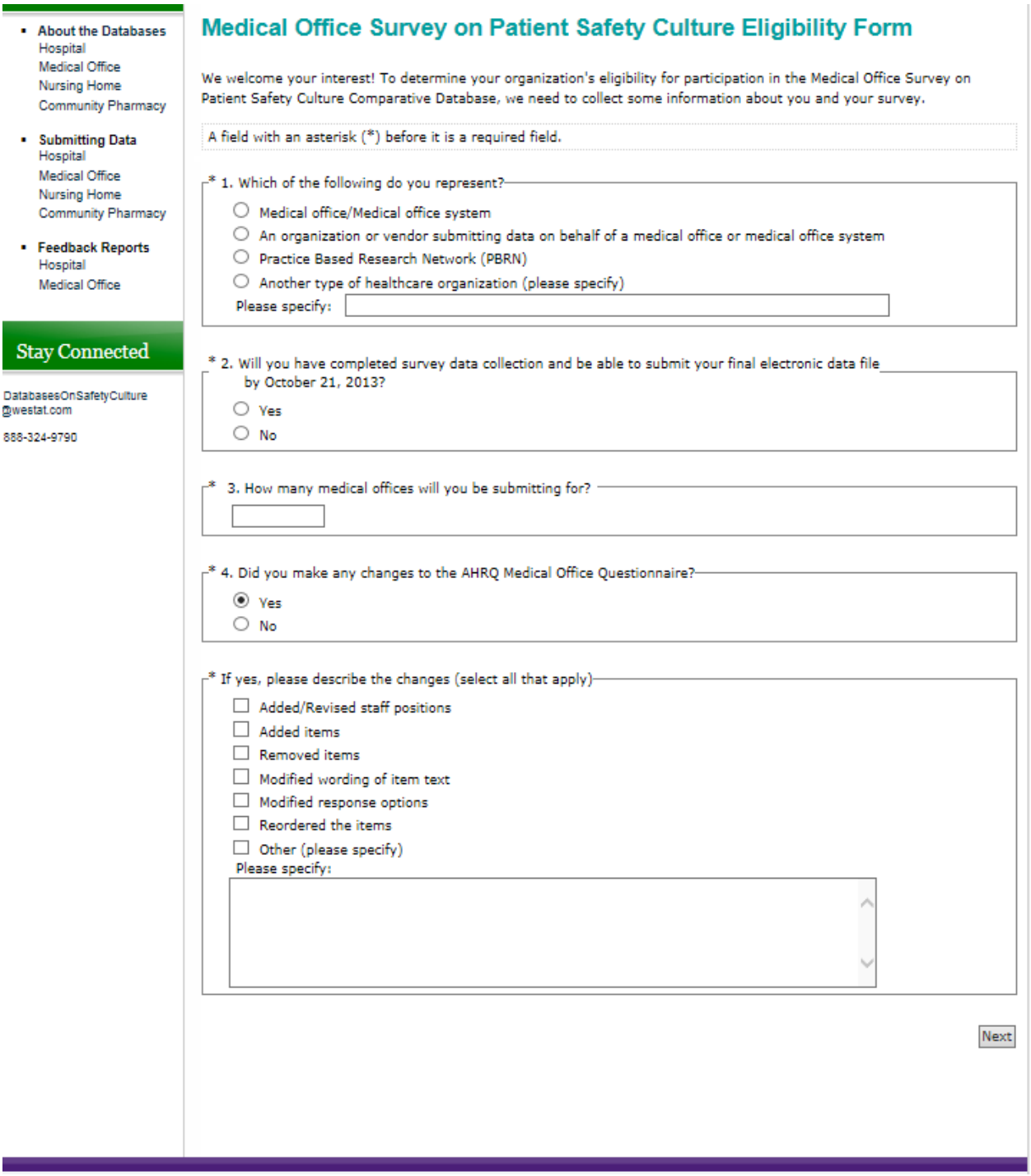
AHRQ Medical Office Survey on Patient Safety Culture Comparative Database, Supporting Statement A

Attachment A: Medical Office Eligibility and Registration Form

Form Approved
OMB No. 0935-XXXX
Exp. Date XX/XX/20XX



- About the Databases
  - Hospital
  - Medical Office
  - Nursing Home
  - Community Pharmacy
- Submitting Data
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  - Medical Office
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  - Community Pharmacy
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888-324-9790

Medical Office Survey on Patient Safety Culture Eligibility Form

We welcome your interest! To determine your organization's eligibility for participation in the Medical Office Survey on Patient Safety Culture Comparative Database, we need to collect some information about you and your survey.

A field with an asterisk (*) before it is a required field.

* 1. Which of the following do you represent?
- ○ Medical office/Medical office system
- ○ An organization or vendor submitting data on behalf of a medical office or medical office system
- ○ Practice Based Research Network (PBRN)
- ○ Another type of healthcare organization (please specify)

Please specify:

* 2. Will you have completed survey data collection and be able to submit your final electronic data file by October 21, 2013?
- ○ Yes
- ○ No

* 3. How many medical offices will you be submitting for?

* 4. Did you make any changes to the AHRQ Medical Office Questionnaire?
- ◉ Yes
- ○ No

* If yes, please describe the changes (select all that apply)
- ☐ Added/Revised staff positions
- ☐ Added items
- ☐ Removed items
- ☐ Modified wording of item text
- ☐ Modified response options
- ☐ Reordered the items
- ☐ Other (please specify)

Please specify:

Next

Public reporting burden for this collection of information is estimated to average 3 minutes per response, the estimated time required to complete the survey. 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: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-XXXX) AHRQ, 540 Gaither Road. Room # 5036. Rockville. MD 20850.

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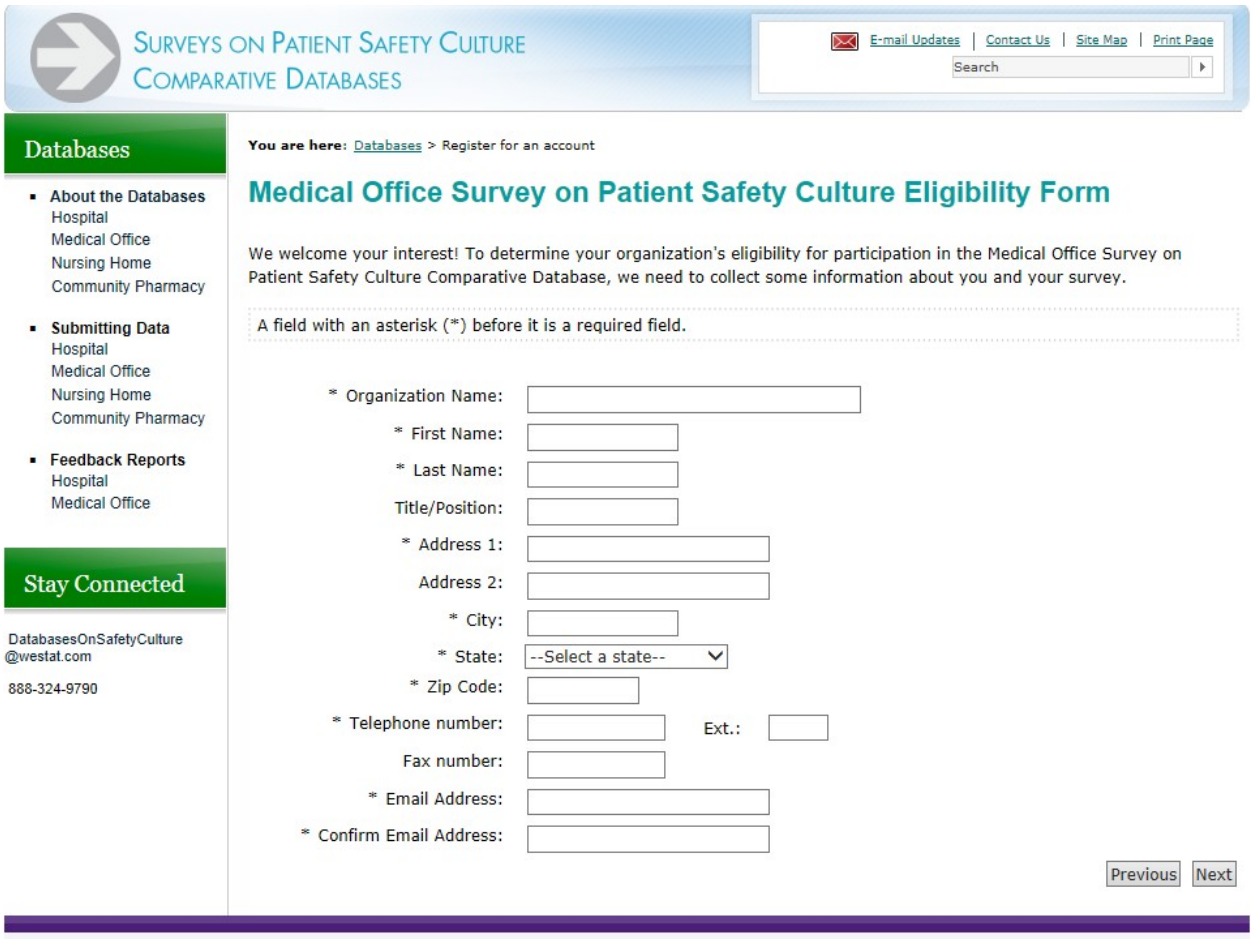

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- About the Databases
  Hospital
  Medical Office
  Nursing Home
  Community Pharmacy
- Submitting Data
  Hospital
  Medical Office
  Nursing Home
  Community Pharmacy
- Feedback Reports
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A field with an asterisk (*) before it is a required field.

* Organization Name:
* First Name:
* Last Name:
Title/Position:
* Address 1:
Address 2:
* City:
* State: --Select a state--
* Zip Code:
* Telephone number: Ext.:
Fax number:
* Email Address:
* Confirm Email Address:

Previous Next

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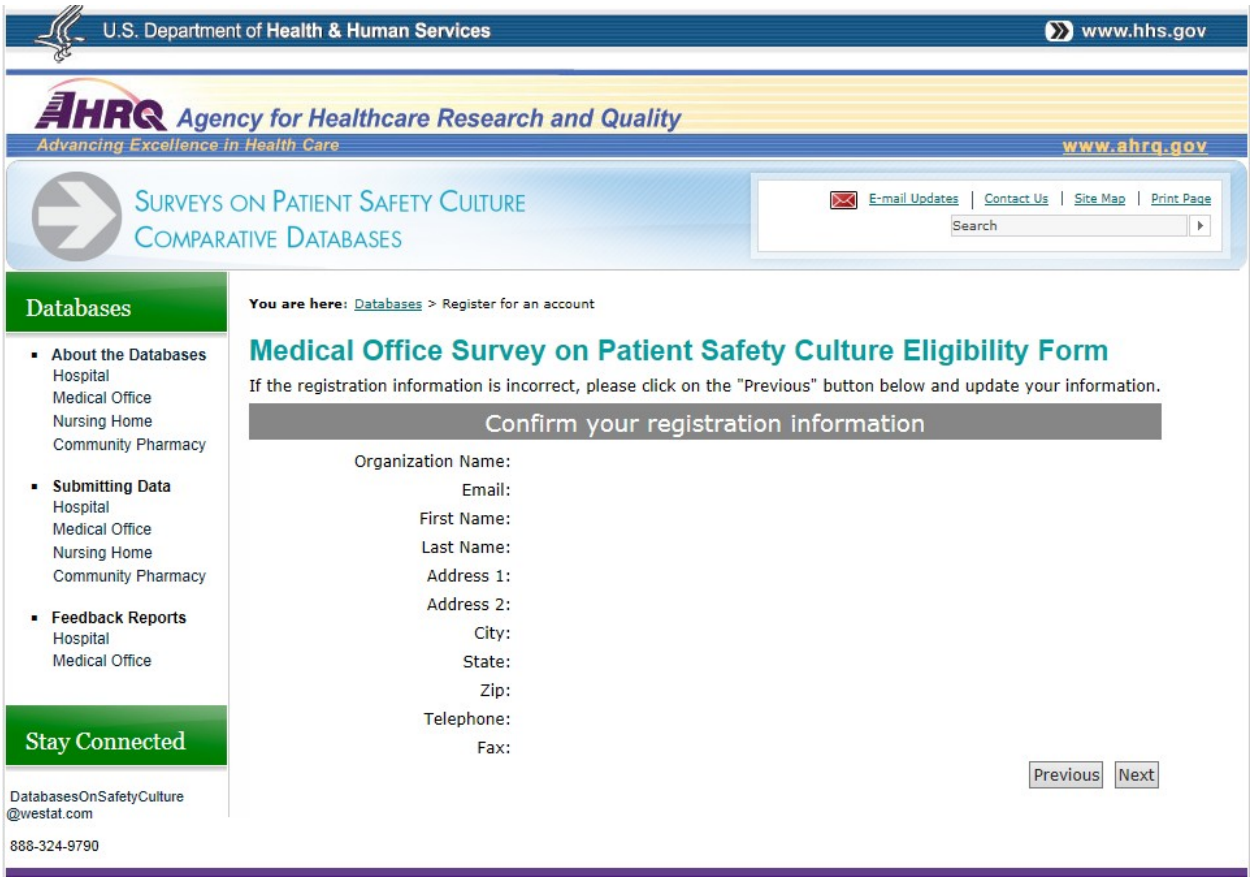

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