

# The Child HCAHPS Data Submission System

## Account Registration

Please provide the following information to register for an account. The information you provide for registration purposes will be kept confidential. The CAHPS Database will review your request and will send you an e-mail with the information to access the 2019 Child HCAHPS Survey Data Submission System.

**\* = Required Field**

**\*Organization Name:**

**\*First Name:**

**\*Last Name:**

**Title Position:**

**\*Address 1:**

**Address 2:**

**\*City:**  \*

**\*State:**  \*

**\*Zip Code:**

**\*Telephone number:** (  )  -  **Ext.:**

**Fax number:** (  )  -

**\*Email Address:**  \*

**\*Role of participant**

- Hospital
- Vendor

**Additional Information about participant role:**

**\*Are you the primary contact?**

- Yes
- No (please give the name and telephone number of the primary contact)

Public reporting burden for this collection of information is estimated to average 5 minutes per response, the estimated time required to complete the form. 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, 5600 Fishers Lane, Rockville, MD 20857.