Hospital Information Submission Form

Please provide the following information. The information you provide for data submission purposes will be kept confidential.

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| --- | --- | --- | --- |
| Hospital Name | Hospital Bed Size | State | Vendor Email |
| Sample Hospital | 100 | MD | [name@vendor.com](mailto:name@vendor.com) |

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.