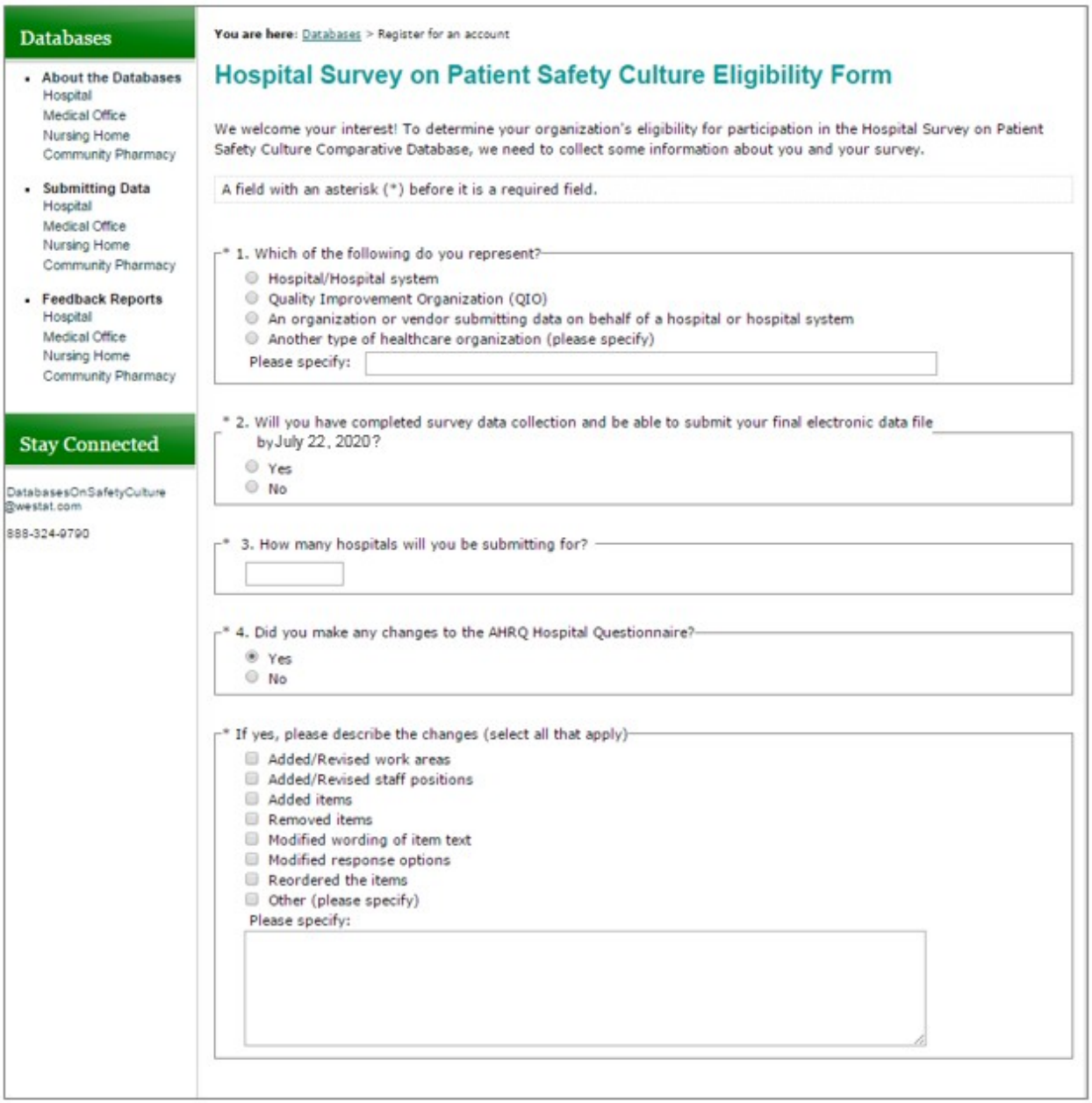
AHRQ Hospital Survey on Patient Safety Culture Database, Supporting Statement A

Attachment A: Hospital Eligibility and Registration Form

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



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Hospital Survey on Patient Safety Culture Eligibility Form

We welcome your interest! To determine your organization's eligibility for participation in the Hospital 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?
- Hospital/Hospital system
- Quality Improvement Organization (QIO)
- An organization or vendor submitting data on behalf of a hospital or hospital system
- 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 July 22, 2020?
- Yes
- No

* 3. How many hospitals will you be submitting for?

* 4. Did you make any changes to the AHRQ Hospital Questionnaire?
- Yes
- No

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

Please specify:

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, 5600 Fishers Lane, Rockville, MD 20857.

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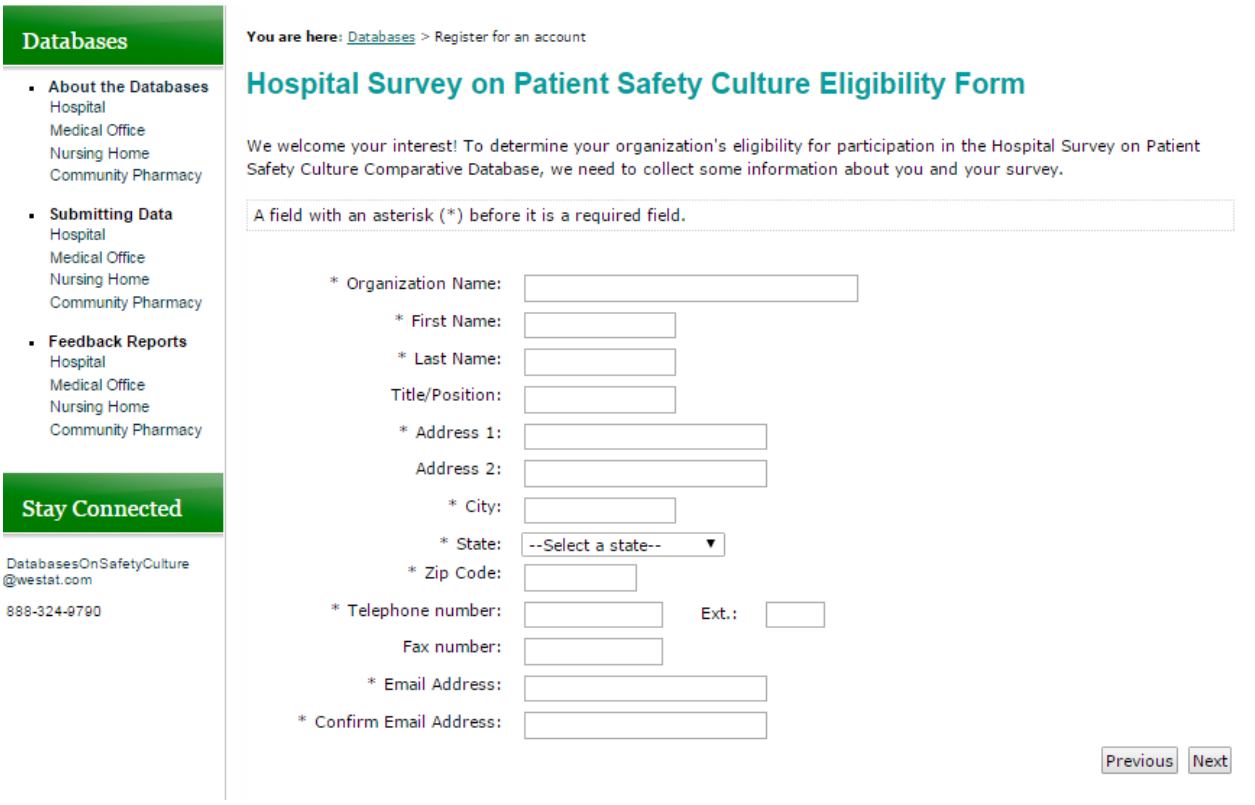

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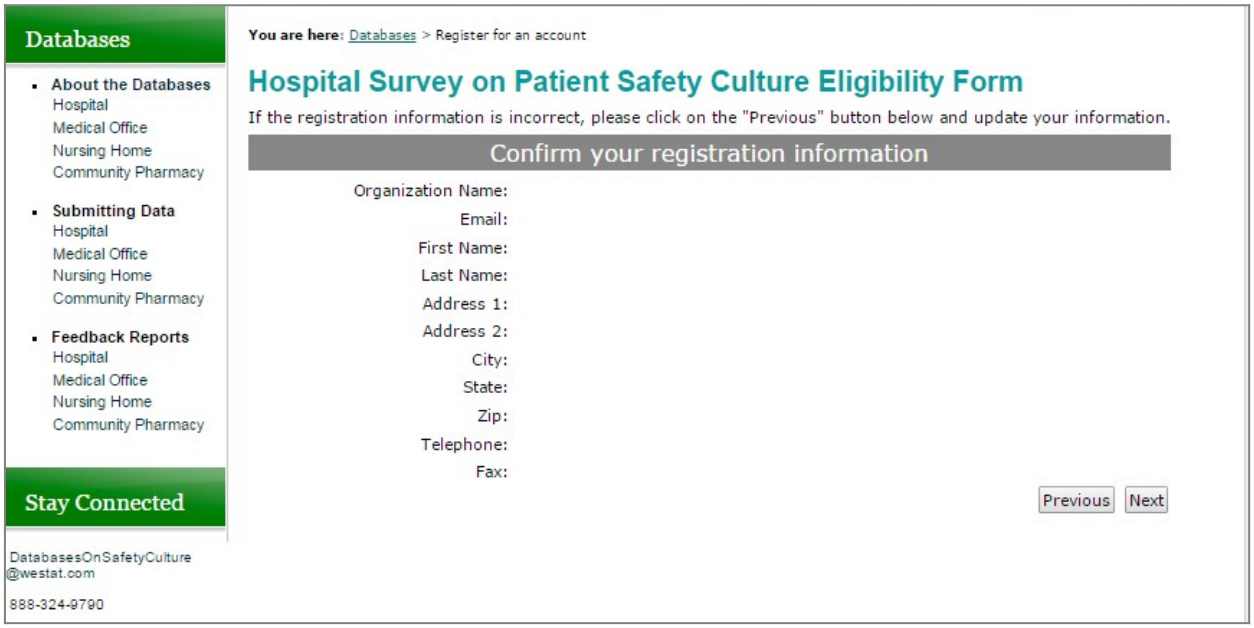
* Organization Name:
* First Name:
* Last Name:
Title/Position:
* Address 1:
Address 2:
* City:
* State: --Select a state--
* Zip Code:
* Telephone number: Ext.:
Fax number:
* Email Address:
* Confirm Email Address:

Previous Next



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Hospital Survey on Patient Safety Culture Eligibility Form

If the registration information is incorrect, please click on the "Previous" button below and update your information.

Confirm your registration information

Organization Name:
Email:
First Name:
Last Name:
Address 1:
Address 2:
City:
State:
Zip:
Telephone:
Fax:

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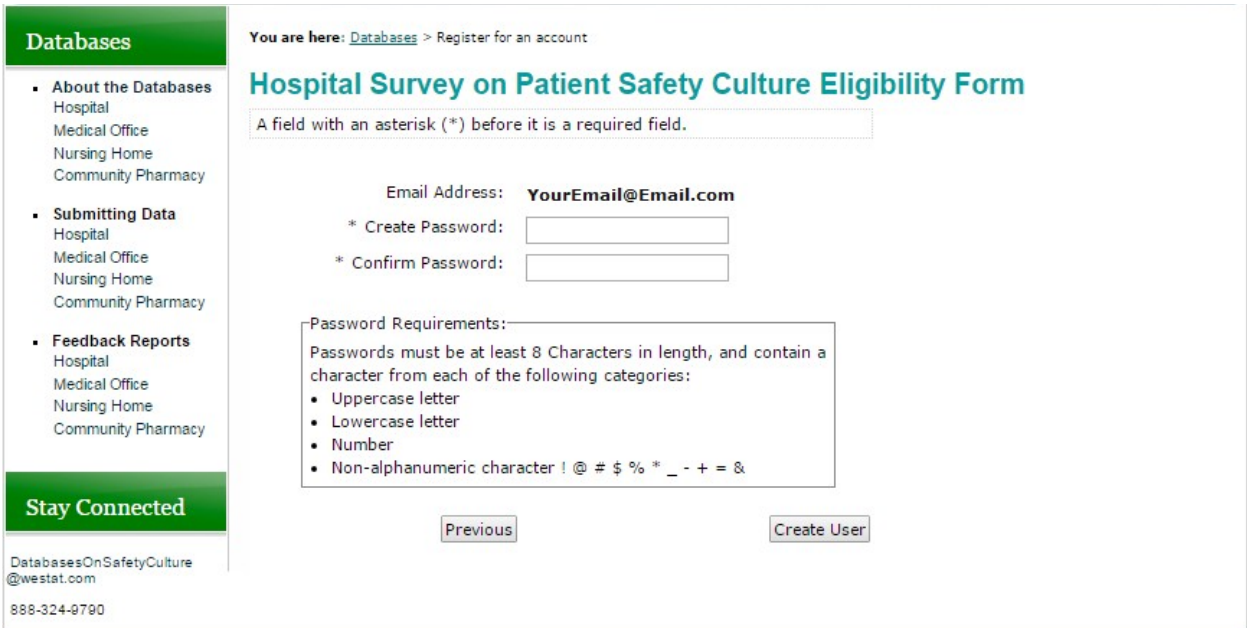

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Hospital Survey on Patient Safety Culture Eligibility Form

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

Email Address: **YourEmail@Email.com**

* Create Password:

* Confirm Password:

Password Requirements:

Passwords must be at least 8 Characters in length, and contain a character from each of the following categories:

- Uppercase letter
- Lowercase letter
- Number
- Non-alphanumeric character ! @ # $ % * _ - + = &

Previous Create User