**HAI & ANTIMICROBIAL USE PREVALENCE SURVEY**

Form Approved

OMB No. **0920-0852**

Exp. Date 03/31/2025

Form Approved

OMB No. **0920**-XXXX

Exp. Date xx/xx/20xx

Form Approved

OMB No. **0920**-XXXX

Exp. Date xx/xx/20xx

**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

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

[ ] Yes

[ ] No

[ ] Unknown

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

[ ] Yes

[ ] No

[ ] Unknown