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

HAI & ANTIMICROBIAL USE PREVALENCE SURVEY
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

4) Does the hospital have an American Medical Association (AMA)-approved residency program?
   ☐Yes
   ☐No
   ☐Unknown

5) Is the hospital a member of the Council of Teaching Hospitals (COTH)?
   ☐Yes
   ☐No
   ☐Unknown