

NHSN Registration Form

Page 1 of 1

*required for saving

Personal Information

*Last Name: _____

*First Name: _____

Middle Name: _____

*Email Address: _____

Facility Identifier

*Please select a facility identifier:

CMS Certification Number (CCN)

AHA ID

VA Station Code

CDC Registration ID

None

*Selected identifier ID: _____

*Facility Type: _____

Facility Administrator Role

As the NHSN facility administrator, will you have an active role in the collection, entry, and/or analysis of data in NHSN, or provide guidance on the use of protocols for the component(s) in which you are enrolling?

_____ Yes _____ No

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. 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 CDC, Reports Clearance Officer, 1600 Clifton Rd., MS H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666).