

NHSN Facility Administrator Change Request Form

Facility Name*: _____
Facility Street Address*: _____
City, State and ZIP*: _____
Date of Request* (MM/DD/YYYY): _____
Facility OrgID (optional) _____
Facility CCN (optional): _____

Current NHSN Facility Admin Name* (FirstName, LastName) _____
Current NHSN Facility Admin Email* _____
Current NHSN Facility Admin Phone* (xxx-xxx-xxxx) _____

New NHSN Facility Admin Name* _____
New NHSN Facility Admin Email* _____
New NHSN Facility Admin Phone* (xxx-xxx-xxxx) _____

Does the new NHSN Facility Admins currently have SAMS access? (optional)
 Yes No

Is the currently listed NHSN Facility Administrator still active at the facility? * (Select one)
 Yes No N/A

If yes, please explain why the currently listed NHSN Facility Administrator is unable to make the reassignment (optional): _____

Important Reminders for NHSN Facility Administrator:

- The NHSN Primary Facility Contact information must be updated in the NHSN application if the listed contact is no longer active at the facility.
- NHSN users who are no longer active at the facility must be deactivated in the NHSN application to avoid unauthorized access to the facility data.

By signing below, you are certifying that you are an executive, director, or in a leadership role for the aforementioned facility. You also certify that all of the information provided above is true and correct to the best of your knowledge and that the NHSN Facility Administrator for the aforementioned NHSN facility should be reassigned by CDC as indicated above.

I agree

Name (FirstName, LastName)*: _____
Job Title/Role*: _____
Email*: _____
Date* (MM/DD/YYYY): _____
Signature: _____

Please allow up to 5 business days for the change request to be verified and completed. **NHSN Email:**
NHSN@cdc.gov

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)).



Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/2026
www.cdc.gov/nhsn

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).