

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

## Attachment B: Site Information Form

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

1107947@westat.com | Logout

**Databases**

Welcome, Mary

Submitting Data

1. Enter Hospital Site Information
2. Submit Hospital Questionnaire
3. Submit Data Use Agreement
4. Submit Survey Data File(s)

Check Your Submission Status

Your Account

Change Password

Edit Contact Information

Logout

**Stay Connected**

888-324-9790

DatabasesOnSafetyCulture@westat.com

OMB Control Number: 0935-0162  
Expiration Date: 8/31/2022

**Site Details**

Save

\* Medicare Provider ID  (length must be 6 characters)

\* AHA ID  (length must be 7 characters)  This hospital does not have an AHA ID.

\* Hospital Name

\* Address

Address 2

\* City

\* State  --Select a state--

\* Zip Code

\* Does this hospital share an AHA ID with another hospital?  Yes  No  Don't Know

\* Please indicate the total number of licensed beds in your hospital.  --Select--

\* Please identify the type of organization that controls and operates your hospital.  --Select--

\* Please indicate your teaching status.  --Select--

**Site Contact Information**

Use my information as the contact for this site

\* Contact First Name

\* Contact Last Name

Title   
Responsible for survey      Ext.   
Email Address

Public reporting burden for this collection of information is estimated to average 5 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.

Value and Efficiency

\* For HSOPs 2.0, how many staff and providers were asked to complete the survey? **This is NOT the same as number of completed surveys.**  (Number of surveys distributed - must be greater than or equal to 10)

\* For HSOPs 2.0, what was the mode used to administer the survey?  --Select a survey mode--

\* Staff Surveyed for HSOPs 2.0  --Select--  
Please specify

\* Data Collection Started  Month:  Year:   
\* Data Collection Completed  Month:  Year:   
(Between July 2024 and July 2026)

\* How long has your hospital had its primary EMR/EHR system?  --Select--

**Please only submit data from your most recent survey administration.**

To continue click **SAVE**

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### Dropdown options for bed size:

<p>* Please indicate the total number of licensed beds in your hospital.</p> <p>* Please identify the type of organization that controls and operates your hospital.</p> <p>* Please indicate your teaching status.</p>	<p>Site Contact Information</p> <p>--Select-- 6-24 beds 25-49 beds 50-99 beds 100-199 beds 200-299 beds 300-399 beds 400-499 beds 500 or more beds</p>
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### Ownership and control:

<p>* Please indicate the total number of licensed beds in your hospital.</p> <p>* Please identify the type of organization that controls and operates your hospital.</p> <p>* Please indicate your teaching status.</p>	<p>Site Contact Information</p> <p>--Select-- Government non federal Nongovernment not-for-profit Investor-owned (for-profit) Government, federal</p>
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### Teaching status:

<p>* Please indicate the total number of licensed beds in your hospital.</p> <p>* Please identify the type of organization that controls and operates your hospital.</p> <p>* Please indicate your teaching status.</p>	<p>Site Contact Information</p> <p>--Select-- Teaching Non Teaching</p>
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### To whom the survey was administered:

<p>* Who Administered to</p> <p>* Data Collection Completed</p>	<p>--Select-- All staff/sample of all staff Selected departments/units only (Please specify) Selected staff positions only (Please specify) Selected departments/units and selected staff positions (Please specify)</p> <p>Month: --Select-- Year: --Select--</p>
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### Survey mode:

<p>* Denominator</p> <p>* Survey Mode</p> <p>* Who Administered to</p>	<p>--Select a survey mode-- Paper Web Mixed Mode (Paper and Web) Other</p>
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### Length of time had EHR system:

\* How long has your hospital had its primary EMR/EHR system?

Please only submit data from your most recent survey admin!

To continue click [SAVE](#)

--Select--

- Less than 1 year
- 1 year to less than 2 years
- 2 years to less than 3 years
- 3 years to less than 5 years
- 5 years to less than 10 years
- 10 years or more
- Don't know