mPINC Screening Questionnaire

A A A

English

Form Approved

OMB #0920-0743

EXP.DATE: MM/DD/YYYY

You are invited to complete a short screening questionnaire to determine if your hospital is eligible to receive the Maternity Practices in Infant Nutrition and Care (mPINC) survey. The mPINC survey is conducted by the Centers for Disease Control and Prevention (CDC) and its questions focus on specific parts of maternity care that affect how babies are fed. If your hospital is determined to be eligible, you or a person you identify will be asked to complete the survey on your hospital's behalf. The screening should take no longer than 2 minutes to complete. Thank you for your participation.

System use notification: This warning banner provides privacy and security notices consistent with applicable federal laws, directives, and other federal guidance for accessing this Government system, which includes all devices/storage media attached to this system. This system is provided for Government-authorized use only. Unauthorized or improper use of this system is prohibited and may result in disciplinary action and/or civil and criminal penalties. At any time, and for any lawful Government purpose, the government may monitor, record, and audit your system usage and/or intercept, search and seize any communication or data transiting or stored on this system. Therefore, you have no reasonable expectation of privacy. Any communication or data transiting or stored on this system may be disclosed or used for any lawful Government purpose.

Public reporting burden of this collection of information is estimated to average 2 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 Road, MS D-74, Atlanta, GA 30329, ATTN: PRA (0920-0743). Do not send the completed form to this address.

Hospital Name

1.A. Is your hospital named _____?
* must provide value

- Yes
- No

reset

1.B. Has your hospital ever been named _____?
* must provide value

- Yes
- No

reset

1.C. What is the current name of your hospital?
* must provide value

Hospital Address

2.A. Is this your hospital's address?

_____
_____
_____
_____
_____
* must provide value

- Yes
- No

reset

2.B. Please provide your hospital's correct address:

Address Line 1: * must provide value
Address Line 2:
City: * must provide value
State: * must provide value
Zip Code: * must provide value

3.A. What is your work telephone number?

4.A. Did your hospital have any births between January 1 and December 31, 2025 or any registered maternity (OB/GYN) beds as of January 1, 2025?
* must provide value

- Yes
- No

reset

5.A. Your hospital is **eligible** for the mPINC survey. The survey includes questions about infant nutrition, such as breastfeeding, use of formula by healthy newborns, and feeding routines, and is best completed by the person most knowledgeable about these types of activities at your hospital. Examples include your hospital's mother-baby nurse manager and nurse manager of the labor and delivery unit. This may be yourself, or another person at your hospital.

Please select the best person to complete the mPINC survey for your hospital.

* must provide value

- ○ I am the best person to complete the mPINC survey
- ○ Another person is the best person to complete the mPINC survey

reset

5.B. Is _____ your email address?

* must provide value

- ○ Yes
- ○ No

reset

5.C. Please provide the name, title, official hospital email, and telephone number for the best person to complete the mPINC survey. To protect the integrity of the survey and privacy of your hospital's information, please do not provide personal email addresses (e.g., Yahoo, Gmail, Hotmail).

Name:		
Title:		
Business email:		* must provide value
Business telephone number:		

You may now click **Submit** to finish the mPINC screening survey. If you selected yourself as the best person to complete the mPINC survey for your hospital, you will be directed to the mPINC survey once you click **Submit**. If you provided the contact information of another person to complete the mPINC survey, they will receive an email invitation to complete the mPINC survey once you click **Submit**.