OMB Approved
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www.cdc.gov/nhsn

COVID-19 Module
Long Term Care Facility: Ventilator Capacity and Supplies

NHSN Facility ID:
CMS Certification Number (CCN):
Facility Name:
***Do you have ventilator dependent unit(s) and/or beds in your facility?** □ YES □ NO **If, NO, Skip this form**
***Date for which responses are reported:** _____/_____/_____

*** For the following questions, please collect data at the same time at least once a week (for example, 7 AM)*

_____	**MECHANICAL VENTILATORs:** Total number available in your facility
_____	**MECHANICAL VENTILATORS IN USE:** Total number of mechanical ventilators in use for residents who have suspected or laboratory positive COVID-19

Ventilator Supplies

Supply Item	Do you currently have any supply?	Do you have enough for one week?
Ventilator supplies (any, including tubing)	□ YES □ NO	□ YES □ NO

CDC estimates the average public reporting burden for this collection of information as 25 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

*Required for saving

**Form to be completed only if facility has ventilator dependent unit(s) and/or beds