

## **Facility Contact Information**

Page 1 of 3							
*required for saving				Tracking #:			
*Facility Name:							
*Main Telephone Nur	nber:						
*Mailing Address:							
*0"	*2 /		*0				
*City:	*County:	or obook "N		*State: *ZIP: -			
For each identifier listed below, enter the # / code or check "Not Applicable" if your facility does not have that identifier: *American Hospital Association ID#:							
•							
*CMS Certification Nu	imber (CCN):		□ Not Applicable				
*VA Station Code:				Not Applicable			
	dentifiers is applicable, ent	ter CDC-pro	vided Enrollment #:				
*Facility Type:							
•	ational in the survey year?	P □ Ye	es 🗆 No				
*NHSN Components	: ment(s) the Facility will use	e initially:					
(Components are ava	ilable only to specific NHS	SN facility typ					
surveillance protocols to determine which component(s) your facility should use within NHSN. Components may be							
added at any time after enrollment.)							
Patient Safety Component			Dialysis Component				
Healthcare Personnel Safety Component			Long Term Care Facility Component				
	ice Component	Outpatient Procedu	Outpatient Procedure Component				
NHSN Facility Admi	nistrator:						
*Name:							
Title:	lifferent from facility)						
*Mailing address: (if different from facility)							
-	1 I I I I I I I I I I I I I I I I I I I						
*City:		*State:		*ZIP: -			
*Telephone Number:	( )	Extension:					
FAX Number: ( )							
Pager Number: ( )							
*Email: *User Name:							
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 10 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 D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).							
CDC 57.101 (Front) Rev. 9, v8.4							



## **Facility Contact Information**

Page 2 of 3								
Patient Safety Primary Contact Person (if different from Facility Administrator)								
*Name:								
Title:								
*Mailing address: (if different from facility)								
*City:		*(	State:		*ZIP: -			
*Telephone Number	:()	E	Extension:	FAX	(Number: ( )			
Pager Number: (	)	*Email:		Valid emai	l account required for enrollment			
<b>Dialysis Facility Pri</b>	imary Contac	t Person (if diffe	erent from Faci	lity Administrator)				
*Name:								
Title:								
*Mailing address: (if	different from	facility)						
		·····						
*City:			State:		*ZIP: -			
*Telephone Number	:()	Extensi	ion:	FAX Number: (	)			
Pager Number: (	<b>\</b>	· ·						
	)	*Email:			l account required for enrollment			
Long Term Care Fa	) Icility Primary		n (if different fr	Valid email om Facility Administr	- -			
Long Term Care Fa *Name:	) Icility Primary		n (if different fr		·			
Long Term Care Fa *Name: Title:		y Contact Perso	n (if different fr		- -			
Long Term Care Fa *Name:		y Contact Perso	n (if different fr		- -			
Long Term Care Fa *Name: Title:		y Contact Perso	n (if different fr		- -			
Long Term Care Fa *Name: Title:		y Contact Perso	n (if different fr		- -			
Long Term Care Fa *Name: Title: *Mailing address: (if		y Contact Perso facility)			ator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City:	different from	y Contact Perso facility)	State:	om Facility Administr	- -			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number	different from	y Contact Perso facility) *: Extensi	State:	FAX Number: (	ator) 			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: (	different from	y Contact Perso facility) k Extensi *Email:	State: ion:	rom Facility Administr FAX Number: ( Valid emai	ator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: ( Healthcare Person	different from	y Contact Perso facility) k Extensi *Email:	State: ion:	FAX Number: (	ator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: ( Healthcare Personi *Name:	different from	y Contact Perso facility) k Extensi *Email:	State: ion:	rom Facility Administr FAX Number: ( Valid emai	ator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: ( Healthcare Personi *Name: Title:	different from : ( ) ) nel Safety Pri	y Contact Perso facility)	State: ion:	rom Facility Administr FAX Number: ( Valid emai	ator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: ( Healthcare Personi *Name:	different from : ( ) ) nel Safety Pri	y Contact Perso facility)	State: ion:	rom Facility Administr FAX Number: ( Valid emai	ator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: ( Healthcare Personi *Name: Title:	different from : ( ) ) nel Safety Pri	y Contact Perso facility)	State: ion:	rom Facility Administr FAX Number: ( Valid emai	ator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: ( Healthcare Personi *Name: Title:	different from : ( ) ) nel Safety Pri	y Contact Perso facility)	State: ion:	rom Facility Administr FAX Number: ( Valid emai	ator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: ( Healthcare Personi *Name: Title: *Mailing address: (if	different from : ( ) ) nel Safety Pri	facility) facility) Extensi *Email: mary Contact Person facility)	State: ion: erson (if differe	rom Facility Administr FAX Number: ( Valid emai	ator)  A count required for enrollment  istrator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: ( Healthcare Person *Name: Title: *Mailing address: (if *City:	different from : ( ) nel Safety Pri different from	y Contact Perso facility) tacility) Extensi *Email: mary Contact Pa facility) facility)	State: ion: erson (if different State:	rom Facility Administration FAX Number: ( Valid emain ent from Facility Admin	ator)			
Long Term Care Fa *Name: Title: *Mailing address: (if *City: *Telephone Number Pager Number: ( Healthcare Personi *Name: Title: *Mailing address: (if	different from : ( ) nel Safety Pri different from	facility) facility) Extensi *Email: mary Contact Person facility)	State: ion: erson (if different State:	FAX Number: ( FAX Number: ( Valid emainer FAX Number: (	ator)  Ator)  Ator)  Atorial account required for enrollment  I account required for enrollment  I account required for enrollment			



## **Facility Contact Information**

Page 3 of 3				
<b>Biovigilance Primary Conta</b>	ct (if different fron	n Facility Admini	strator)	
*Name:				
Title:				
*Mailing address: (if different	from facility)			
				- <u></u>
*City:		*State:		*ZIP: -
*Telephone Number: ( )		nsion:	FAX Number: (	)
Pager Number: ( )	*Email:			il account required for enrollment
<sup>+</sup> Microbiology Laboratory D	irector/Superviso	r (if different fron	n Facility Administrate	or)
<sup>+</sup> Optional for Dialysis Facilities				
*Name:				
Title:				
*Mailing address: (if different	from facility)			
				<u></u>
*City:		*State:		*ZIP: -
*Telephone Number: ( )		Extension:	FAک	(Number: ( )
Pager Number: ( )	*Email:		Valid ema	il account required for enrollment
<b>Outpatient Procedure Prima</b>	ary Contact (if diffe	erent from Facilit	y Administrator)	
*Name:				
Title:				
*Mailing address: (if different	from facility)			
*City:		*State:		*ZIP: -
*Telephone Number: ( )	Exter	nsion:	FAX Number: (	)
Pager Number: ( )	*Email:		Valid ema	il account required for enrollment