Missouri Cancer Registry Hospital Directory Update Form

ATTN: PLEASE COMPLETE AND MAIL, FAX OR E-MAIL TO Hope Morris

Please complete all applicable information:

HOSPITAL NAME:
_____

ADDRESS (Street, City, Zip)
_____

ADMINISTRATOR (Title and credentials):_____Phone:_____

SUPERVISOR (Title & credentials):_____

HOSPITAL DEPARTMENT_____Phone:_____

CONTACT PERSON (Include Title(s):
_____

HOSPITAL DEPARTMENT:
_____

E-MAIL ADDRESS:
_____

CONTACT PHONE: _____ FAX: _____ HOSP. PHONE_____

2nd CONTACT PERSON (Optional):_____

2nd CONTACT PHONE: _____ E-MAIL ADDRESS:
_____

BED SIZE: _____ REPORTING STATUS: _____ Incidence _____ Survival

ESTIMATED NUMBER OF CANCER CASES REPORTED ANNUALLY:
_____

DO YOU REPORT CASES FOR ANOTHER HOSPITAL? _____YES _____ NO

NAME OF HOSPITAL(S):
_____

REPORTING MECHANISM: _____ Computerized (indicate software)
_____
_____ Manual
_____ Circuit-riding (less than 75 cases annually)

ACoS ACCREDITED: _____ YES ___ NO REGISTRY REFERENCE YEAR: _____

DATE UPDATED: _____

_____

Please return form to:

Hope Morris, Missouri Cancer Registry, PO Box 718, Columbia, MO 65205

Or

Hope Morris, fax number 573-884-9655

Or

Hope Morris, e-mail: morrisho@health.missouri.edu