Nebraska Public Health Data Exchange Registration

Name and contact for the person completing this form:

First Name _____ Date: _____
Last Name _____
Email _____

For which public health data registries are you registering? Organization Type:

_____ _____

Hospital CCN

_____

3rd Party Data Interface Vendor

Are you contracted with a 3rd party data interface vendor?

- ◯ Yes
- ◯ No

Vendor Name

_____

Vendor interface(s)

- ☐ Immunizations
- ☐ Electronic Lab Reporting
- ☐ Syndromic Surveillance

Immunization

Immunization information

- ☐ IMM VXU
- ☐ IMM QBP

VXU ORG ID

_____

QBP ORG ID

_____

Cancer Registry

Is your Electronic Health Record (EHR) system capable of sending pathology reports electronically?

- ◯ Yes
- ◯ No

Please contact DHHS.NebraskaCancerRegistry@nebraska.gov to send pathology reports electronically using software called eMaRC Plus (instead of Web Plus).

Is the cancer program Commission on Cancer (CoC) accredited?

- ◯ Yes
- ◯ No

For more information please visit:
https://www.facs.org/quality-programs/cancer-programs/commission-on-cancer/coc-accreditation/categories/

Category of CoC accreditation:	◯ Academic Comprehensive Cancer Center Program (ACAD ◯ Community Cancer Program (CCP) ◯ Comprehensive Community Cancer Program (CCCP) ◯ Free-Standing Cancer Center Program (FCCP) ◯ Hospital Associate Cancer Program (HACP) ◯ Integrated Network Cancer Program (INCP) ◯ NCI-designated Comprehensive Cancer Center Program (NCIP) ◯ NCI-Designated Network Cancer Program (NCIN) ◯ Pediatric Cancer Program (PCP) ◯ Veterans Affairs Cancer Program (VACP)
Report volume in the previous year	◯ Less than 50 cases ◯ More than or equal to 50 cases
Hospital registry software used for electronic reporting	_____
Report file format Standard XML file (https://www.naaccr.org/data-standards-data-dictionary/)	◯ NAACCR ◯ Non-NAACCR standard
Has your facility ever reported pediatric, adolescent, and young adult cancer (PAYAC) patients, aged from 0-29 years?	◯ Yes ◯ No
Please report those cases within 30 days of diagnosis	

Site information

Site Information

*Fields with an asterisk are required

*Site Name: Department:

_____ _____

*Site Address:

_____

*City: *State: *Zip:

_____ _____ _____

County:

_____

Phone:

_____

Primary Contact (with whom will Nebraska DHHS work?):

*Fields with an asterisk are required.

*First Name: *Last Name: *Title:

_____ _____ _____

Phone number: Ext.: Fax:

_____ _____ _____

*E-mail:

_____

Is this reporter a Certified Tumor Registrar (CTR)?	◯ Yes ◯ No
Contractor Agency Name, if applicable.	_____
Alternate Contact (in case primary contact is unavailable): First Name: Last Name: Title: _____ _____ _____ Phone number: Ext.: Fax: _____ _____ _____ E-mail: _____	
Is this reporter a Certified Tumor Registrar (CTR)?	◯ Yes ◯ No
Contractor Agency Name, if applicable.	_____
Are you submitting for multiple providers, provider sites, and/or hospital sites?	◯ Yes ◯ No
STEP 1: Download this Excel File and complete the fields listing all affiliated health systems or provider organizations. [Attachment: "Mult Provider Name_ Facility List_.xlsx"]	
STEP 2: Upload the file by pressing the upload button on the right.	
Name of Individual EP's (Eligible Professionals) or Hospital applying for attestation:	_____
NPI#'s of Individual EP's (Eligible Professionals) or Hospital NPI# (this is a 10 digit number)	_____
Group NPI# (for those using the Group NPI to apply for PI):	_____
Are you registering for Promoting Interoperability attestation?	◯ Yes ◯ No
Do you have your Promoting Interoperability reporting period dates established? NOTE: You CAN test any time before the end date of your attestation reporting period. You CANNOT test after your attestation reporting period has ended.	◯ Yes ◯ No
Start Date of Promoting Interoperability Reporting Period:	_____
End Date of Promoting Interoperability Reporting Period:	_____

Name:

Title:

Mailing Address:

City:

State:

Zip Code:

Email address:

Current EHR Software Vendor:

Future EHR Software Vendor

EHR product and version:

ONC Certified EHR Number

Note: If you don't know your ONC#, please go to: https://chpl.healthit.gov/

What version of HL7 is the EHR using?
NOTE: HL7 2.5.1 is required for Promoting Interoperability Stage 3.

- ◯ 2.3.1
- ◯ 2.5.1
- ◯ Both

Technical (IT) Contact Person

Name:

Title:

Phone:

Ext

Email address:

The Public Health Information Network Messaging System (PHINMS) Contact (if other than technical/IT contact)

Name: _____

Title: _____

Phone: _____

Ext: _____

Email Address: _____

For purposes of sending us data, do you have PHINMS already installed and configured with us?
◯ Yes
◯ No

If you have a CDC-assigned OID for use as your PartyID for PHINMS, please enter it below: _____

Upload Documents

Upload a Document by Clicking on "Upload File"

_____

Password _____

hidden file upload field containing the pdf of completed responses

Status (Admin Only)

Has this been submitted to the registries?

◯ Yes
◯ No