1. **Please complete this form electronically and save the file**
2. **Use two forms if more space is needed**
3. **Email the completed form as an attachment to clewis@crgc-cancer.org**

4. **"Hospital Contact" MUST be a hospital employee - HIM Director or hospital employee that hired the contractor**
5. **List the primary abstracting contact under "Contact Name"**
6. **If Non-eligible ODS please list duties performed next to name**

Reporting Facility Abstractor Information Form *(one facility per form)*

Facility Name:

Facility ID Number:

Hospital Contact/Title:

Hospital Contact/E-mail:

Hospital Contact/Phone:

Number of Abstractors:

Cancer Reporting Software Used:

Date:

Contact Name:

Phone Number:

Fax Number:

E-mail:

Contact's Supervisor:

Supervisor's E-mail:

Abstractor Name Designate a secondary abstracting contact with a asterisk after their name	Initials*	Indicate whether Employee or Vendor		If working remotely, enter physical location (i.e. City, State, Country)	If Vendor, provide name of agency or service	ODS Status		If Non-ODS, indicate if ODS eligible		If ODS, provide ODS#**
		Employee	Vendor			ODS	Non-ODS	Yes	No	

**Include all initials and/or numbers the named abstractor uses in cancer reporting software.*

***The ODS number begins with the year the ODS exam was successfully taken.*