

**Ohio Cancer Incidence Surveillance System (OCISS)
PHYSICIAN OFFICE CANCER REPORTERS**

1. Physician/Practice Name: _____
2. OCISS Reporting Source ID (if known): _____
3. Address (street, city, zip): _____
4. Office Manager: _____
5. E-mail for Office Manager: _____
6. Phone Number for Office Manager: _____
7. Does this office report cancer cases diagnosed and/or treated at this practice or is reporting done by someone else?
____ YES, reporting is done by this office
____ NO, reporting is done by someone else
If NO, who is reporting: _____
8. Does this office report cancer cases for any other physicians or practices?
____ NO
____ YES
If YES, for which other physicians or practices do you report: _____

9. Please list who is reporting cancer cases for this office (even if reporting is done by someone external to this office):
 - a) Name (first, middle initial, last) _____
Email _____
Phone (____) _____
 - b) Name (first, middle initial, last) _____
Email _____
Phone (____) _____

Please return completed form by e-mail or fax to:
Ohio Cancer Incidence Surveillance System
Bureau of Health Promotion; Office of Health Improvement and Wellness
Ohio Department of Health
E-mail: OCISS@odh.ohio.gov; Fax: (614) 644-8028

Thank You!