Ohio Department of Health (ODH)
Ohio Cancer Incidence Surveillance System (OCISS)
AMBULATORY SURGERY/RADIATION THERAPY CENTER/LAB REPORTERS

1. Facility Name: ____

2. OCISS Reporting Source ID (if known): ______________________________

3. Address (street, city, zip): ____________________________________

4. ODH ID#/License#/HCF# (if applicable): __________________________

5. Office Manager: ____

6. E-mail for Office Manager: _____________________________________

6. Phone Number for Office Manager: ________________________________

7. Does this facility report cancer cases diagnosed and/or treated at this facility or is reporting done by someone else?

   _____ YES, reporting is done by this facility

   _____ NO, reporting is done by someone else

   If NO, who is reporting: ____

8. Does this facility report cancer cases for any other facilities or physician practices?

   _____ NO

   _____ YES

   If YES, for which other facilities or physician practices do you report: _______________

   ____

9. Please list who is reporting cancer cases for this facility (even if reporting is done by someone external to this facility):

   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!