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!