Newborn Screening Participant Form

Participant Information

Name of Hospital/Provider _____

Address _____

City_____ State_____ Zip Code_____

Participant Type:

- ☐ Hospital
- ☐ Physician
- ☐ Service Provider

Participant - Technical Point of Contact

Primary Contact_____

Phone_____ Email_____

Secondary Contact_____

Phone_____ Email_____

Participant - Nursery Point of Contact

Primary Contact_____

Phone_____ Email_____

Secondary Contact_____

Phone_____ Email_____

Participant - Lab Point of Contact

Primary Contact_____

Phone_____ Email_____

Secondary Contact_____

Phone_____ Email_____

Information Required for Data Exchange

1. Facility Name (Participant): _____
2. Facility OID (For Participant): _____
3. DCLS-assigned Submitter Code: _____
   (*Same as currently entered on NBS Dried Bloodspot Card*)
4. Does your organization intend to use a third-party service provider for NBS Data exchange?

   ☐ Yes ☐ No

IF your answer to #4 was YES, please skip to #9. You do not need to fill out #5-8 as those data elements will be provided by your designated third-party service provider.

5. Sending Application Name: _____
6. Sending Application OID: _____
7. IP address(es) from which your organization will send data:

8. Preferred format for SSL certificate:

   ☐ .pem
   ☐ .p12
   ☐ Other (please specify) _____

9. Can electronically send and/or receive (*Select all that apply*):

   ☐ NBS Orders
   ☐ NBS Results

10. From the sending application, can generate a bar coded label displaying ALL fields currently on the NBS Dried Bloodspot Card?

    ☐ Yes ☐ No

11. Our organization has read through the Onboarding Guide and understands the requirements needed for successful implementation:

    ☐ Yes ☐ No