



SUBSCRIBER REGISTRATION FORM
Health Care Organizations

Subscriber Name

(Liaison between ASHA and the organization)

ASHA Membership Number

Name of Healthcare System

Facility Name

Preferred Mailing Address

Telephone Number

Fax Number

E-mail Address

A. SYSTEM INFORMATION: *(For purposes of NOMS, a healthcare system is a collection of facilities under one umbrella organization).*

1. Is your organization/program part of a larger health care system?

YES _____ **NO** _____

2. If yes, will your entire health care system be participating in NOMS?

YES _____ **NO** _____

3. Indicate the anticipated number of facilities within your system that will be collecting NOMS data:

B. FACILITY INFORMATION: (For purposes of NOMS, a Facility is a central location or building for one or more treatment programs (e.g., outpatient, home health, inpatient rehabilitation, etc.).)

Please complete the following information for each facility that will be collecting NOMS data. Duplicate this sheet and use a separate copy for each facility.

Name of Facility:	
Facility Address:	
Telephone Number:	

For this facility, indicate the types of programs that will be included in the NOMS data collection:

Pre-K	Adults	
		Acute Hospital
		Inpatient Rehab
		Subacute
		Skilled Nursing
		Home Health
		Outpatient Rehab
		Comprehensive Outpatient Rehab
		Day Treatment
		Assisted Living
		Office-Based
		Other _____

C. CLINICIAN INFORMATION: Please provide the names and ASHA/NSSHLA membership numbers of all prospective clinicians who will be participating in NOMS data collection. This information will be used to grant each user access to the NOMS Online User Training. (Use additional pages, if necessary)

	NAME	ASHA/NSSHLA #
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Please mail this completed form along with the signed letter of agreement to:

NOMS Project Administrator
 American Speech-Language-Hearing Association
 2200 Research Boulevard #245
 Rockville, MD 20850