



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

Email: [OCISS@odh.ohio.gov](mailto:OCISS@odh.ohio.gov)

Fax: (614) 644-8028

**Thank you!**