



## Newborn Screening Participant Form – Exhibit A

### Participant Information

Name of Hospital/Provider \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Participant Type:

- Hospital
- Physician
- Service Provider (i.e. OZ Systems)



### 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 OZ systems as the third-party service provider for NBS Data Exchange with DCLS?  
 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. Transport supported for Data Exchange (*Select one*):  
 SFTP (please enter IP address of server uploading SFTP messages to ConnectVirginia) \_\_\_\_\_  
 HTTPS (please enter Domain name connecting to ConnectVirginia) \_\_\_\_\_
8. Preferred format for SSL certificate:  
 .pem  
 .p12  
 Other (please specify) \_\_\_\_\_
9. Can electronically send and/or receive (*Select all that apply*):  
 NBS Orders (NBSORDERS)  
 NBS Results (NBSResults)
10. From the sending application, can generate a bar coded label displaying **ALL** fields currently on the NBS Dried Bloodspot Card?  
 Yes  
 No

.....