Patient Data Reporting
Agent Designation Form

In order to designate a third party agent to submit data on your behalf, your facility must complete this form. All information must be provided, including a signature from a facility administrator or primary contact.

Please print clearly

Section 1: Facility Information *(all information is required)*

1. FACILITY ID NUMBER:	**2.** FACILITY NAME:
3. DATA TYPE(S): ☐ Inpatient ☐ Emergency Department ☐ Ambulatory Surgery Check one or more Data Type(s). *If none are checked, the Agent will be given access to all Data Types associated with your facility.*	
4. FACILITY BUSINESS ADDRESS (MAILING ADDRESS):	
5. FACILITY CONTACT NAME:	6. TITLE:
7. PHONE:	8. EMAIL ADDRESS:

Section 2: Designated Agent Information *(all information is required)*

9. NAME OF DESIGNATED AGENT (COMPANY NAME):	
10. BUSINESS ADDRESS (MAILING ADDRESS):	
11. CONTACT NAME:	
12. PHONE:	13. EMAIL ADDRESS:
DESIGNATION EFFECTIVE DATE	
14. EFFECTIVE REPORT PERIOD BEGIN DATE:	Designation is effective until OSHPD receives written notification of revocation or new designation.

By signing this document, I certify that I am an official of my facility and I am approving the aforementioned Designated Agent to submit data on behalf of my facility for the designated data type(s) and effective date.

15. NAME (PRINT):	16. TITLE:
17. SIGNATURE:	18. DATE: