

STS *Participant* Contact Form

**FORM MUST BE COMPLETED FOR NEW PARTICIPANTS
AND FOR CURRENT PARTICIPANTS WITH UPDATES**

ALL STS National Database Participants:

(Select one): _____ NEW _____ CURRENT

If current, enter Participant ID # (five digits): _____

Section 1: NEW STS National Database Participants

(Complete Section 1 AND Section 3 and fax to Gerry Tarafa, STS Operations Administrator at 312/202-5867)

- a) Select which Database you wish to participate in:
- _____ *Adult Cardiac Surgery*
_____ *General Thoracic Surgery*
_____ *Congenital Heart Surgery*
- b) Software Vendor Name: _____
Date of software purchase: _____
- c) Complete Section 3: Demographic Information

Section 2 – CURRENT STS National Database Participants: UPDATES

- a) **Surgeon Representative or Participant Surgeon Updates:** All participants with surgeon changes must inform STS. Complete Section 3 – Demographic Section with appropriate changes. Please note, if adding a surgeon, a signature on Schedule A is also required. (Schedule A can be obtained online at www.sts.org/participate.)
- b) **Vendor Updates:** Vendor changes must be sent to STS prior to harvesting your site's data.
- Former vendor and dates used: _____
New vendor and Date of Software Purchase: _____

FAX All Surgeon and Vendor Updates to Gerry Tarafa, STS Operations Administrator at (312)202-5867

- c) **All Other Updates:** Complete Section 3 – Demographic Section with appropriate changes.

FAX All Other Updates to Duke Clinical Research Institute (DCRI) at (919)668-7074

Section 3 – Demographic Information (fields marked with * are required)

Complete, at a minimum, the required information and select all appropriate roles (STS National Database Participant Roles and Description below) for all Contacts. If you are adding a surgeon you must include NPI.

Contact Information Section

<i>For address, no PO Boxes please.</i>	<i>Check all appropriate Roles for each</i>
<p>*Name: _____</p> <p>*Organization: _____</p> <p>Department: _____</p> <p>Title: _____</p> <p>*Address: _____</p> <p>*Address (line two): _____</p> <p>*City: _____</p> <p>*State/Province: _____ *MailCode: _____</p> <p>*Phone: _____ Ext.: _____ *Fax: _____</p> <p>*EMAIL ADDRESS: _____</p> <p>*(SURGEON ONLY) This surgeon is Board Certified Yes _____ NO _____</p> <p>*(SURGEON ONLY) If yes, list specialty: _____</p> <p>*(SURGEON ONLY) Surgeon NPI Number _____</p>	<p>_____ Surgeon Representative</p> <p>_____ Participant Surgeon</p> <p>_____ Primary Data and File Contact</p> <p>_____ Backup Data and File Contact</p> <p>_____ Data Quality Report Recipient</p> <p>_____ Contract Contact</p> <p>_____ CQI Champion</p> <p>_____ National Report Recipient</p> <p>_____ Billing Contact</p> <p>_____ Other</p> <p>*Please indicate if you are adding _____ or deleting _____ this contact.</p>
<i>For address, no PO Boxes please.</i>	<i>Check all appropriate roles for each</i>
<p>*Name: _____</p> <p>*Organization: _____</p> <p>Department: _____</p> <p>Title: _____</p> <p>*Address: _____</p> <p>*Address (line two): _____</p> <p>*City: _____</p> <p>*State/Province: _____ *MailCode: _____</p> <p>*Phone: _____ Ext.: _____ *Fax: _____</p> <p>* EMAIL ADDRESS : _____</p> <p>*(SURGEON ONLY) This surgeon is Board Certified Yes _____ NO _____</p> <p>*(SURGEON ONLY) If yes, list specialty: _____</p> <p>*(SURGEON ONLY) Surgeon NPI Number _____</p>	<p>_____ Surgeon Representative</p> <p>_____ Participant Surgeon</p> <p>_____ Primary Data and File Contact</p> <p>_____ Backup Data and File Contact</p> <p>_____ Data Quality Report Recipient</p> <p>_____ Contract Contact</p> <p>_____ CQI Champion</p> <p>_____ National Report Recipient</p> <p>_____ Billing Contact</p> <p>_____ Other</p> <p>*Please indicate if you are adding _____ or deleting _____ this contact.</p>

For address, no PO Boxes please.

Check all appropriate roles for each

*Name: _____

*Organization: _____

Department: _____

Title: _____

*Address: _____

*Address (line two): _____

*City: _____

*State/Province: _____ *MailCode: _____

*Phone: _____ Ext.: _____ *Fax: _____

* EMAIL ADDRESS : _____

*(SURGEON ONLY) This surgeon is Board Certified Yes _____ NO _____

*(SURGEON ONLY) If yes, list specialty: _____

*(SURGEON ONLY) Surgeon NPI Number _____

_____ Surgeon Representative

_____ Participant Surgeon

_____ Primary Data and File Contact

_____ Backup Data and File Contact

_____ Data Quality Report Recipient

_____ Contract Contact

_____ CQI Champion

_____ National Report Recipient

_____ Billing Contact

_____ Other

*Please indicate if you are adding _____ or deleting _____ this contact.

*Name: _____

*Organization: _____

Department: _____

Title: _____

*Address: _____

*Address (line two): _____

*City: _____

*State/Province: _____ *MailCode: _____

*Phone: _____ Ext.: _____ *Fax: _____

* EMAIL ADDRESS : _____

*(SURGEON ONLY) This surgeon is Board Certified Yes _____ NO _____

*(SURGEON ONLY) If yes, list specialty: _____

*(SURGEON ONLY) Surgeon NPI Number _____

_____ Surgeon Representative

_____ Participant Surgeon

_____ Primary Data and File Contact

_____ Backup Data and File Contact

_____ Data Quality Report Recipient

_____ Contract Contact

_____ CQI Champion

_____ National Report Recipient

_____ Billing Contact

_____ Other

*Please indicate if you are adding _____ or deleting _____ this contact.

*Name: _____

*Organization: _____

Department: _____

Title: _____

*Address: _____

*Address (line two): _____

*City: _____

*State/Province: _____ *MailCode: _____

*Phone: _____ Ext.: _____ *Fax: _____

* EMAIL ADDRESS : _____

*(SURGEON ONLY) This surgeon is Board Certified Yes _____ NO _____

*(SURGEON ONLY) If yes, list specialty: _____

*(SURGEON ONLY) Surgeon NPI Number _____

_____ Surgeon Representative

_____ Participant Surgeon

_____ Primary Data and File Contact

_____ Backup Data and File Contact

_____ Data Quality Report Recipient

_____ Contract Contact

_____ CQI Champion

_____ National Report Recipient

_____ Billing Contact

_____ Other

*Please indicate if you are adding _____ or deleting _____ this contact.

STS National Database Participant Roles and Descriptions

The **Surgeon Representative*** is identified by The Society of Thoracic Surgeons Schedule A Contract that requires the signature of the lead surgeon representative.

The **Primary Data and File Contact*** receives all correspondence related to harvesting and reporting STS data. The Data Warehouse permits only one Primary Data and File Contact per facility.

The **Backup Data and File Contact*** assists the Primary Data and File Contact with matters related to harvesting and reporting STS data. The Data Warehouse permits more than one Backup Data and File Contact per facility.

The **Data Quality Report Recipient*** automatically receives the Data Quality Report (DQR) via e-mail. The report provides information about the submitted data file and data that was accepted into the database, as well as any issues encountered with your data file or its submission. In response to the user's request, the Data Warehouse permits more than one Data Quality Report Recipient per facility. Due to the importance of the Data Quality Report, sites are encouraged to select more than one individual who can review the report for its accuracy.

The **Contract Contact*** handles the questions and concerns related to The Society of Thoracic Surgeons contractual issues.

The **Continuous Quality Improvement (CQI) Champion** is involved in quality improvement. This role was originally limited to sites participating in The Society of Thoracic Surgeons grant activities. The Data Warehouse permits more than one CQI Champion per facility.

The **Participant Surgeon** is identified by The Society of Thoracic Surgeons Schedule A Contract that requires the signature of a participating surgeon. ALL OTHER SURGEONS IN ADDITION TO THE SURGEON REPRESENTATIVE ARE TO BE IDENTIFIED ON THE CONTACT FORM AS "PARTICIPATING SURGEONS."

The **National Report Recipient*** is sent The Data Analyses of The Society of Thoracic Surgeons National Database report for distribution to the site staff. The Data Warehouse permits only one National Report Recipient per facility.

The **Billing Contact*** is the individual to be invoiced for the participation fees.

The **Other** contact is an auxiliary contact for the participating site.

****Email address is required. STS will not accept the contact information without a valid email address.***