



Membership Application

Center Name _____
 Address 1 _____
 Address 2 _____
 City _____ State _____ Zip _____
 Country _____ NICU phone number _____

Please fill out all contact fields below

TEAM LEADER

This contact is responsible for overseeing all activities involved in Vermont Oxford Network (VON) participation by:

- *coordinating data submission, reporting, education, and quality improvement activities*
- *ensuring the appropriate staff fulfill critical VON roles*
- *servicing as your center's primary advocate for data science and quality improvement*
- *encouraging your center's staff to fully utilize VON information and tools*

Contact Name _____
 Address _____
 City _____ State _____ Zip _____
 Country _____ Email _____
 Phone _____ Fax _____

REPORT CONTACT

This contact should be a member of your center's peer review committee and be active in quality improvement activities. The Report Contact is responsible for:

- *receiving a printed copy of your center's Annual Report and electronic copies of other Vermont Oxford Network (VON) reports*
- *sharing reports and findings with the applicable team members at your center*
- *ensuring that the appropriate staff are aware of and have access to the Nightingale reporting tool*
- *Report Contacts are automatically granted access to VON Members Area - Data Management and issued a VON Web Services Login*

Contact Name _____
 Address _____
 City _____ State _____ Zip _____
 Country _____ Email _____
 Phone _____ Fax _____



DATA CONTACT

This contact is responsible for collection and submission of all infant data to Vermont Oxford Network (VON) by:

- *establishing and overseeing procedures for data collection and submission*
- *developing an Eligibility Verification Plan and monitors its implementation*
- *collecting and submitting infant data to VON or, depending on the size of your center, supervising the data collection and submission tasks*
- *verifying that all eligible infants are included in your center’s data submissions*
- *receiving all Network correspondence regarding data status, submission, and errors*
- *confirming that the data conform to all definitions and conventions of the VON database*
 - *Data Contacts are automatically granted access to VON Members Area - Data Management and issued a VON Web Services Login*

Contact Name _____
Address _____
City _____ State _____ Zip _____
Country _____ Email _____
Phone _____ Fax _____

FINANCIAL CONTACT

This contact’s responsibilities include:

- *handling Vermont Oxford Network (VON) membership agreements*
- *ensuring VON membership payment*

Contact Name _____
Address _____
City _____ State _____ Zip _____
Country _____ Email _____
Phone _____ Fax _____

NEONATOLOGIST

This contact supports your center’s Vermont Oxford Network (VON) membership by:

- *answering medical questions from your center’s Data Collector pertaining to the VON data definitions*
- *receiving, evaluating, and distributing information from VON about ongoing clinical trials, research projects, and quality improvement collaboratives*

Contact Name _____
Address _____
City _____ State _____ Zip _____
Country _____ Email _____
Phone _____ Fax _____



QUALITY LEADER

This contact is the person in your center who is responsible for:

- *assessing quality indicators, and providing information to and ideally participating in quality and healthcare improvement projects*
- *if not part of your team, this person may be at the Program, Division, or Organizational level*

Contact Name _____
Address _____
City _____ State _____ Zip _____
Country _____ Email _____
Phone _____ Fax _____

APPLICATIONS CONTACT

This contact is on your IT team and is an Applications Analyst or someone who is similarly qualified. The Applications Contact is responsible for:

- *planning for the integration, hosting, and support of VON software for your organization*
- *servicing as an effective communicator between VON and your center's team members who have advanced technical skills and/or final decision making authority*
- *applications may include software hosted on VON's web site, software hosted at your organization, and potential integration with third party medical record applications*

Contact Name _____
Address _____
City _____ State _____ Zip _____
Country _____ Email _____
Phone _____ Fax _____

SENIOR LEADER

This contact should be a member of your center's executive management team (CEO, CNO, CQO).

Contact Name _____
Address _____
City _____ State _____ Zip _____
Country _____ Email _____
Phone _____ Fax _____

NICU MANAGER

Contact Name _____
Address _____
City _____ State _____ Zip _____
Country _____ Email _____
Phone _____ Fax _____

CHIEF OF NEONATOLOGY

Contact Name _____
Address _____
City _____ State _____ Zip _____
Country _____ Email _____
Phone _____ Fax _____



DATABASE CHOICE / PARTICIPATION START DATE

Your reports will be of greatest value if you submit a complete calendar year of data (Jan. 1 to Dec. 31)

Very Low Birth Weight Database

Expanded Database (includes VLBW)

First year of participation _____

YOUR CENTER’S FINANCIAL STRUCTURE

Is your center:

Wholly owned and managed

Leased

Contract managed

A subsidiary of another corporate organization

Other (please specify)

Are any of the actions or financial decisions of your organization overseen or approved by another corporate entity?

Yes

No

If so, please identify the entity. _____

YOUR CENTER’S OWNERSHIP STRUCTURE

Government (federal or non-federal)

Non-government, not for profit (nfp) (church operated or other not-for-profits including nfp corporations)

Investor owned, for profit (individual, partnership, or corporations)

Other (please specify)

Is your center part of a hospital system (owned, leased, sponsored, or managed by a central organization)?

Yes

No

If yes, please identify which system you are part of:



YOUR CENTER'S NETWORKS

Is your center part of a hospital network (a group of hospitals, physicians, other providers, insurers, and/or community agencies that voluntarily work together to coordinate and deliver health services?)

Yes No

If yes, please identify which network(s).

Does your center participate in state or regional improvement collaboratives?

Yes No

If yes, please identify which collaboratives(s).

Is your NICU staffed by a contracted physician group?

Yes No

If yes, please identify which group. _____

Is your center a free-standing children's hospital?

Yes No

INFORMATION TECHNOLOGY AND ELECTRONIC HEALTH RECORDS

Who provides your information technology (IT) support?

- An internal IT staff
- IT staff at network or parent organization
- An external vendor

Are you using an electronic medical record in the NICU?

Yes No

If yes, who provides your primary EHR/EMR? _____

Will you use your EHR/EMR to electronically submit data to VON, either through eNICQ6 or VON EDS?

- Yes, file import to eNICQ6
- Yes, file submitted directly to VON EDS
- No

Thank you. We look forward to working with you.