



STATE OF MISSOURI  
 DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 BUREAU OF COMMUNICABLE DISEASE CONTROL AND PREVENTION  
**MRSA VRE REPORTING**

**GENERAL INFORMATION**

Send completed form:

By MAIL:  
 Missouri Department of Health and Senior Services  
 Bureau of Communicable Disease Control and Prevention  
 PO Box 570  
 Jefferson City, MO 65102

FAX:  
 573-526-0235

OR EMAIL:  
 HAI\_Reporting@health.mo.gov

**FACILITY INFORMATION**

NAME OF FACILITY	TYPE OF FACILITY (HOSPITAL, SURGICAL CENTER)	NUMBER OF BEDS
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ADDRESS

CITY	STATE	ZIP CODE	COUNTY
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NAME OF CONTACT	TELEPHONE NUMBER	FAX NUMBER	EMAIL ADDRESS
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**DATA**

REPORTING QUARTER (CHECK ONE)      YEAR \_\_\_\_\_

January-March       April-June       July-September       October-December

Total number of nosocomial isolates of *S. aureus* for reporting quarter: \_\_\_\_\_

Number of nosocomial isolates of *S. aureus* sensitive to methicillin (oxacillin, etc.) for reporting quarter: \_\_\_\_\_

Total number of nosocomial isolates of enterococci for reporting quarter: \_\_\_\_\_

Number of nosocomial isolates of enterococci sensitive to vancomycin for reporting quarter: \_\_\_\_\_

I hereby certify that all of the information provided on this form is complete and true to the best of my knowledge.

SIGNATURE OF CONTACT	DATE
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