

CRStar Client Update Form

ERS #	
Date:	

To be filled out by the Cancer Registry Supervisor. Please return the completed form to your CRStar representative.

Registry Supervisor / Manager Information

Name	
Title	
Email Address	
Phone Number	
Name of Health System / Hospital	
Cancer Registry Mailing Address (#, Street & Suite)	
Cancer Registry Mailing Address (City, State & Zip)	

Billing Information (please let us know where we need to send your invoices)

Name	
Email Address	
Please only fill the remaining fields if y	ou wish to receive mailed invoices via USPS
Name of person to receive invoice	
Invoice Mailing Address (#, Street & Suite)	
Invoice Mailing Address (City, State & Zip)	

Legal Information (please tell us where to send legal documents - i.e. contract renewals, addendums, etc.)

Name:	
Email Address:	

Please provide information for the following individuals

	Name	Email Address	Phone #
Director – Oncology Division:			
Director – Oncology Clinical Leadership:			
Oncology IT Specialist:			

Please provide the names of all employees who have been granted System Admin permissions in CRStar

Please list all facilities for which your registry collects data (please see page 3 for additional fields if necessary)

Facility	City				
		Who is your current Medical Records Radiology Oncology	:	try ve	ndor for:
		Pathology			
		ls your cancer registr	ry?		
		CoC Accredited?	Yes	No	Unknown
		NAPBC Accredited?			
		NCI Accredited?			
		NAPRC Accredited?			

Do you use a contracting company	for registry services?	Yes	No	
Name of contracting company				

Please provide the following information for all users of CRStar at your facility/facilities

(Please see page 3 for additional fields, if necessary)

Name	Title	Email address	Phone number

Additional facilities (continued)

Facility	City

CRStar users (continued)