

**PRIMARY CARE ASSESSMENT TOOLS:
USER'S AGREEMENT**

Type of Organization

- | | |
|---|--|
| <input type="checkbox"/> State MCH program | <input type="checkbox"/> Local MCH program |
| <input type="checkbox"/> Federal MCH agency | <input type="checkbox"/> Local Medicaid office |
| <input type="checkbox"/> Other state health agency (Specify.) _____ | <input type="checkbox"/> Other local health department program (Specify.) _____ |
| <input type="checkbox"/> Group practice | <input type="checkbox"/> Health care plan (Specify.) |
| <input type="checkbox"/> School of Public Health | <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity |
| <input type="checkbox"/> Other university program (Specify.) _____ | <input type="checkbox"/> Consulting firm |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Other (Specify.) _____ |

Anticipated Main Focus of the Project

- Needs assessment for new programs or funding, or for budget (re)allocations
- Plan continuing education offerings for (Specify.) _____
- Identify changes in the characteristics of primary care delivery related to (Specify.) _____
- Medical home evaluation

Anticipated Project Details

Sample size: _____

Survey instrument (Check all that apply.): Consumer Facility/Provider

Mode of administration: Telephone Mail Other (Specify.) _____

Do you have plans to prepare a report or set of analyses for external distribution?

- No
- Yes (Specify.) _____

Agreement

I acknowledge that I have been granted permission to use the Primary Care Assessment Tool surveys for the purposes mentioned above and will not photocopy, reproduce, or distribute these surveys for any other purpose. I understand that this agreement does not include permission to sell these instruments. I understand that to maintain consistency and data quality, the surveys should be reproduced exactly as they appear in *Primary Care Assessment Tools Manual*.

I understand that I must obtain permission from Dr. Starfield and/or Dr. Shi before making any changes to any Primary Care Assessment Tool instrument.

I understand that I may not translate any Primary Care Assessment Tool unless permission is specifically requested and granted by Dr. Starfield and/or Dr. Shi.

I agree that, if I use one or more forms of the Primary Care Assessment Tool, I will notify Dr. Starfield of its use, include a citation to any published paper regarding this instrument or to the website describing it (www.jhsph.edu/pcpc/pca_tools.html), and notify Dr. Starfield of its publication.

Signature of user	Date	B. Starfield or L. Shi	Date
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Name _____
 Organization _____
 Address _____

 Telephone _____
 Fax _____

Return two copies with signature to:

B. Starfield
 Johns Hopkins University
 624 North Broadway, Room 452
 Baltimore, MD 21205

A copy signed by a developer will be returned to you.

NOTE: Dr. Starfield can be reached at bstarfie@jhsph.edu; Dr. Shi can be reached at lshi@jhsph.edu.