



# mPINC Screening Questionnaire

English  

**Form Approved**  
**OMB #0920-0743**  
**EXP.DATE: MM/DD/YYYY**

You are invited to complete a short screening questionnaire to determine if your hospital is eligible to receive the Maternity Practices in Infant Nutrition and Care (mPINC) survey. The mPINC survey is conducted by the Centers for Disease Control and Prevention (CDC) and its questions focus on specific parts of maternity care that affect how babies are fed. If your hospital is determined to be eligible, you or a person you identify will be asked to complete the survey on your hospital's behalf. The screening should take no longer than 2 minutes to complete. Thank you for your participation.

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Hospital Name	
1.A. Is your hospital named ____? <i>* must provide value</i>	<input type="radio"/> Yes <input type="radio"/> No <a href="#">reset</a>
1.B. Has your hospital ever been named ____? <i>* must provide value</i>	<input type="radio"/> Yes <input type="radio"/> No <a href="#">reset</a>
1.C. What is the current name of your hospital? <i>* must provide value</i>	<input type="text"/>
Hospital Address	
2.A. Is this your hospital's address? _____ _____ _____ _____ <i>* must provide value</i>	<input type="radio"/> Yes <input type="radio"/> No <a href="#">reset</a>
2.B. Please provide your hospital's correct address:	
Address Line 1: <input type="text"/>	<i>* must provide value</i>
Address Line 2: <input type="text"/>	
City: <input type="text"/>	<i>* must provide value</i>
State: <input type="text"/>	<i>* must provide value</i>
Zip Code: <input type="text"/>	<i>* must provide value</i>
3.A. What is your work telephone number?	<input type="text"/>
4.A. Did your hospital have any births between January 1 and December 31, 2025 or any registered maternity (OB/GYN) beds as of January 1, 2025? <i>* must provide value</i>	<input type="radio"/> Yes <input type="radio"/> No <a href="#">reset</a>

5.A. Your hospital is **eligible** for the mPINC survey. The survey includes questions about infant nutrition, such as breastfeeding, use of formula by healthy newborns, and feeding routines, and is best completed by the person most knowledgeable about these types of activities at your hospital. Examples include your hospital's mother-baby nurse manager and nurse manager of the labor and delivery unit. This may be yourself, or another person at your hospital.

Please select the best person to complete the mPINC survey for your hospital.

\* must provide value

- I am the best person to complete the mPINC survey
- Another person is the best person to complete the mPINC survey

reset

5.B. Is \_\_\_\_ your email address?

\* must provide value

- Yes
- No

reset

5.C. Please provide the name, title, official hospital email, and telephone number for the best person to complete the mPINC survey. To protect the integrity of the survey and privacy of your hospital's information, please do not provide personal email addresses (e.g., Yahoo, Gmail, Hotmail).

Name:

Title:

Business email:  \* must provide value

Business telephone number:

You may now click **Submit** to finish the mPINC screening survey. If you selected yourself as the best person to complete the mPINC survey for your hospital, you will be directed to the mPINC survey once you click **Submit**. If you provided the contact information of another person to complete the mPINC survey, they will receive an email invitation to complete the mPINC survey once you click **Submit**.