

A Plan for Revising Morbidity Reporting by States★

(The following committee report is published for the benefit of the many readers of the CDC Bulletin to whom the nationally reported communicable diseases are of interest. The report includes recommendations with respect to procedures for the reporting of communicable disease morbidity through the National Office of Vital Statistics; revision of the minimum list of diseases to be reported nationally; and a new proposal that a regular procedure for the reporting of epidemics be established.)

The committee report was submitted to the Association of State and Territorial Health Officers at their annual meeting in the fall of 1950 and has been distributed to the State Health Officers.

The Public Health Service Committee on Communicable Disease Reporting was composed of the following: Dr. Joseph A. Bell, National Health Institutes; Dr. Selwyn D. Collins, Division of Public Health Methods; Dr. G. L. Dunnahoo, Division of Foreign Quarantine; Dr. Paul W. Kabler, Environmental Health Center; Dr. Alexander Langmuir, Communicable Disease Center; Dr. Robert E. Serfling, Communicable Disease Center; and Dr. Halbert L. Dunn, Chairman, National Office of Vital Statistics.)

INTRODUCTION

During the forty-eighth annual conference of the State and Territorial Health Officers held October 19-22, 1949, in Washington, D.C., the Infectious Disease Committee made a number of recommendations to the Public Health Service. This document was prepared in response to two of these recommendations:

1. Proceedings, Page 65, Paragraph IIc – “That the U.S. Public Health Service and the American Public Health Association study the diseases which are now reportable in the various States and territories and make recommendations concerning the diseases which should be made reportable.”

2. Proceedings, Page 65, Paragraph IVa – “... the U.S. Public Health Service study and survey present morbidity reporting requirements for all notifiable diseases and that recommendations be made concerning any changes which may be deemed advisable.”

The recommendations presented here cover three aspects of the morbidity reports and statistics problem – a minimum list of diseases for reporting by the States to the Public Health Service, a revision of the periodic statistical reports now being made to the Public Health Service, and the minimum content of a general morbidity case report form.

These recommendations have been developed by the Public Health Service Committee on Communicable Disease Reports, representing the various parts of the Service concerned with this problem. It is believed that they constitute a first step toward the achievement of more comparable and useful reports on the incidence of communicable diseases throughout the country and the occurrence of epidemic outbreaks. They will also provide some of the epidemiological information which would be needed in an emergency war-time situation.

It will be recognized that these recommendations are only a beginning. The most important uses of morbidity reports are found in the local and State health departments. It is, therefore, proposed that the States and the Public Health Service also cooperate in the development of minimum procedures for the collection and processing of morbidity reports which can be recommended for use throughout the country.

SUMMARY OF MAJOR RECOMMENDATIONS

1. Universal national reporting by States to the National Office of Vital Statistics should be encouraged as follows:

- a. Immediate telegraphic reports of the five diseases now required by international convention.

*A report of the Public Health Service Committee on Communicable Disease Reports.

b. Immediate weekly reports (current preliminary figures) of State totals for a minimum list of notifiable diseases.

c. Weekly mail reports (current preliminary figures) of the same diseases by county.

d. Annual reports (corrected final figures) of an expanded list of diseases, giving State totals by week and county totals for the year.

2. The minimum list of diseases recommended for national reporting should be reviewed at intervals for additions, deletions, and appropriate changes in terminology.

3. In addition to the minimal list, States are encouraged to include other diseases reportable within the State. The National Office of Vital Statistics will publish annually the additional disease reports submitted by the States.

4. A new mechanism will be established for the weekly reporting of epidemics and outbreaks as they occur in the Nation and for their appropriate publication in brief narrative form.

THE BASIS FOR NATIONAL MORBIDITY REPORTING

In addition to State and local needs for morbidity reporting in communicable disease control, there are several reasons for national morbidity reporting.

1. Immediate control procedures may be necessary to meet "international or interstate quarantine obligations."

2. The national interest will be served by the rapid and systematic dissemination of information to health officials, practicing physicians, and the general public.

3. Civil defense against biological warfare requires immediate central notification of outbreaks of disease.

4. Comprehensive statistical data are needed for epidemiological research and for administrative planning of long-range programs.

The first three of these reasons justify immediate reporting on a daily, or at least weekly, basis with rapid dissemination of information as the primary objective. This rapidity inherently limits the accuracy and correctness of such data, but it is essential if control measures are to be instituted with minimum delay.

On the other hand, the fourth reason demands the most accurate and complete data possible. Corrected and specific information is needed for the diseases requiring immediate reporting and, in addition, data on a number of other diseases not

requiring immediate control action are necessary in planning and directing long-range investigation and control programs. Such information can become available only after a period of weeks or months when supplemental data have been accumulated. Hence, an annual report giving these corrected and more complete data is recommended. This report should be submitted by April 30 of the following year.

However, definite limitations must be placed on the list of nationally reportable diseases. Inclusions should be restricted to diseases of recognized national importance that can be reasonably well diagnosed by clinical means alone or by generally available laboratory services.

The minimum list should be considered flexible. The present revisions of morbidity reporting are proposed for experimental trial during 1951. The procedures adopted at the close of 1951 will be reviewed thereafter at 5-year intervals. However, under emergency conditions, revisions may be made at any time.

An intrinsic feature of the plan is that States will be encouraged to report all diseases which are public health hazards within the States. It is recommended, however, that national reporting be requested only for the minimum list of diseases.

RECOMMENDED MINIMUM LIST OF DISEASES FOR NATIONAL REPORTING

In preparing the list in table 1 and subsequent tables, a number of sources were consulted:

1. Report of Subcommittee on Communicable Disease Control, Committee on Research and Standards, APHA, 1950.

2. Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death, Sixth Revision of the International Lists of Diseases and Causes of Death, 1948.

3. Diseases presently defined as "communicable" in Interstate Quarantine Regulations, PHS Reg. Par. 72.2.

4. *Morbidity Reporting Requirements*, Division of Public Health Methods, USPHS, July 1, 1948.

5. Lists of notifiable diseases in the States.

None of these have been accepted without qualification or suggested changes. Brief justifications are presented for additions or deletions from the established lists at present in general use.

The relations of venereal disease and tuberculosis reporting to general communicable disease reporting have been considered. However, these diseases present special reporting problems because of the intensive control programs which they

involve. It is believed that the extent to which the reporting of these diseases should be coordinated with other communicable disease reporting requires further investigation during the proposed trial year.

Weekly Reporting. The modified list of 25 diseases, recommended for weekly reporting by the States, is given in table 1. The APHA Subcommittee recommends reporting of all these diseases except infectious encephalitis. Recognized international or interstate quarantine obligations exist for 14 of them. The five diseases, cholera, plague, smallpox, epidemic typhus (louse-borne), and yellow fever are immediately reportable by telegram in accordance with international convention.

Weekly State totals for these diseases should

be reported promptly, and in addition, county totals should be submitted by mail. The former will be published by the National Office of Vital Statistics; the latter will be available at one central point to public health officials and any interested citizen.

While the weekly report by county represents a substantial body of statistical data, it is recommended because almost all States now regularly make these tabulations for local purposes and submit them to the National Office of Vital Statistics.

Six diseases have been eliminated from the list included in the 1948 edition of *Morbidity Reporting Requirements*. Three of these six are presently included in the list of defined "communicable" diseases in Public Health Service Regulations, Paragraph 72.2. These are favus, ringworm of the scalp, and trachoma.

Favus is so rare and so local a problem in this country that routine national reporting is no longer justified.

Ringworm of the scalp is a very common, mild disease of purely local concern. Morbidity reporting on an individual case basis has no validity.

Trachoma is now a sufficiently uncommon and localized problem that reporting on an annual basis should suffice.

The other three diseases, previously reported weekly by telegram, that have been deleted are influenza, pneumonia, and paratyphoid fever.

Reports of influenza are notoriously inaccurate and more useful data regarding the occurrence of this disease will be obtained by the proposed plan for reporting of epidemics.

Pneumonia is so grossly under-reported that morbidity statistics of this disease have been totally valueless. Since there is no hope of changing this situation, the disease should be dropped from the list.

Paratyphoid fever is a vague clinical entity and has usually

Table 1
DISEASES RECOMMENDED FOR WEEKLY REPORTING BY STATES TO PHS
State Totals by Telegram, County Totals by Mail

Name of Disease	Presently Included in International or Interstate Quarantine Regulations	Reporting Recommended by APHA Subcommittee, 1950
1. Anthrax	x	x
2. Botulism		x
3. Brucellosis		x
4. Cholera	x	x
5. Dengue	x	x
6. Diphtheria	x	x
7. Encephalitis, infectious	x	
8. Infectious jaundice (including infectious hepatitis, serum hepatitis, and leptospirosis)		x
9. Malaria		x
10. Measles		x
11. Meningococcal meningitis and meningococcemia	x	x
12. Pertussis		x
13. Plague	x	x
14. Poliomyelitis	x	x
15. Psittacosis	x	x
16. Rabies in man		x
17. Rabies in animals		x
18. Rocky Mountain spotted fever		x
19. Smallpox	x	x
20. Streptococcal infections including scarlet fever	x	x
21. Trichinosis		x
22. Tularemia		x
23. Typhoid Fever	x	x
24. Typhus Fever	x	x
25. Yellow Fever	x	x

been grouped with cases of typhoid fever. The newly added provision for annual reports of salmonellosis should provide more useful information.

The following diseases have been added to the weekly list: botulism, brucellosis, dengue, infectious jaundice (including infectious hepatitis, serum hepatitis, and leptospirosis), malaria, rabies in man, trichinosis, and endemic typhus (flea-borne).

Botulism is a rare type of food poisoning that has in the past resulted from nationally distributed canned food. Its occurrence is of national interest.

Brucellosis is a disease for which increasing control activities on a national scale are being attempted. Epidemics traced to raw milk have occurred occasionally. These might well involve more than one State.

Dengue is not known to be present in this country but its introduction should be known immediately.

Infectious jaundice is a general term encompassing at least three specific entities that can be distinguished only by careful and often prolonged investigation. These entities are:

a. Infectious hepatitis, an endemic and epidemic disease communicable from man to man and through water and possibly other means. It was of major importance to the military forces overseas in World War II. Occurrence of epidemics is of national interest.

b. Serum hepatitis is transmitted by blood transfusions, blood serum or plasma, through biological products containing human blood serum, and by contaminated needles and syringes. Occurrence of cases in different States might be traceable to one lot of a nationally distributed product. Routine weekly reporting would facilitate bringing such an epidemic to light so that control measures could be instituted.

c. Leptospirosis is a specific spirochetal disease that occurs endemically and epidemically and is of increasing national interest.

While routine reports of jaundice will not distinguish these three entities, their normal incidence is low. Any increase above expectancy would warrant special investigations.

Malaria as an endemic disease is rapidly disappearing from the country but the prevention of its possible re-establishment is a Federal responsibility for which current information is required.

Rabies in man is rare but is of wide interest when it occurs.

Trichinosis is a disease that occurs in epidemics traceable to infected meat. These may well have interstate implications of importance not only to official health agencies but also to the Bureau of Animal Industry of the Department of Agriculture.

Endemic typhus fever has been subjected to an intensive federally coordinated control program. Immediate knowledge of the occurrence of such cases is needed in the effective execution of the program.

Annual Reporting. The list of diseases that should be reported annually, table 2, differs from the weekly list in several respects:

a. Tabulations are to be corrected for duplicates, changes in diagnosis, and laboratory reports, and allocation by date of onset and to place of residence.

b. Laboratory confirmations are to be requested on certain diseases where clinical diagnosis is often inadequate.

c. Additional diseases are included for which weekly reports are deemed unnecessary.

d. Paralytic cases of poliomyelitis are to be specified.

e. The extent to which "infectious" jaundice has been distinguished into its three components as a result of subsequent investigation is to be indicated.

The corrected tabulations on an annual basis giving State totals by weeks and annual totals by counties will serve the valuable purpose of revealing when, where, and to what extent the current weekly uncorrected reports were in error. These will be of inestimable value for research studies and long-range administrative planning.

The new suggestion of indicating in the annual reports the number of cases of certain diseases confirmed by laboratory examination will be valuable in the interpretation of the validity of the reports. It is an established practice in most States for laboratories to submit reports on examinations for communicable diseases to the State epidemiologist. This practice should be encouraged.

The additional diseases included in the annual list but not on the weekly list are infectious gastro-enteritis (amebiasis - laboratory confirmed only, salmonellosis - laboratory confirmed only, shigellosis - laboratory confirmed only, and unspecified), leprosy, ophthalmia neonatorum,

totals of these diseases is of national value in reflecting local problems. The National Office of Vital Statistics will publish simple annual totals

of all notifiable diseases submitted by the States. A partial list of such diseases is presented in table 3.

Table 3

**A PARTIAL LIST OF DISEASES OF IMPORTANCE IN COMMUNICABLE DISEASE CONTROL
BUT NOT INCLUDED IN THE MINIMUM LIST FOR NATIONAL REPORTING**

A. Infectious Diseases		
Actinomycosis	Moniliasis	
Ascariasis	Mononucleosis, infectious	
Aseptic meningitis	Mumps	
Blastomycosis	Pediculosis	
Chickenpox	Pneumonia	
Coccidioidomycosis	Puerperal sepsis	
Colorado tick fever	Q fever	
Conjunctivitis, acute infectious	Rat bite fever	
Echinococcosis	Relapsing fever	
Erysipelas	Rheumatic fever, acute	
Favus	Rickettsialpox	
Filariasis	Ringworm of the scalp	
Gas gangrene	Rubella	
Glanders	Scabies	
Histoplasmosis	Schistosomiasis	
Hookworm	Tapeworm infestation	
Impetigo contagiosa	Trypanosomiasis, American (Chagas' disease)	
Influenza	Vincent's infection	
Keratoconjunctivitis	Vulvovaginitis in children	
Lymphocytic choriomeningitis		
B. Noninfectious Diseases		
Dietary deficiency diseases	Metabolic diseases	
Beriberi	Diabetes	
Pellagra	Goiter	
Scurvy	Methemoglobinemia of infants	
Rickets		
Toxicological diseases	Complications following various immunization procedures	
Barbiturate poisoning	Tetanus following smallpox vaccination	
Carbon monoxide poisoning	Paralysis following Pasteur treatment	
Lead poisoning	Anaphylactic reactions following egg vaccines	
Other	Post-vaccinal encephalitis	
Occupational diseases	Miscellaneous	
Dermatitis	Accidents	Blindness
Silicosis	Cancer	Dog bite
Other pulmonary fibroses	Epilepsy	
Radiation sickness	Erythroblastosis	
	Multiple sclerosis	
	Toxemias of pregnancy	
	Yaws	

totals of these diseases is of national value in reflecting local problems. The National Office of Vital Statistics will publish simple annual totals

of all notifiable diseases submitted by the States. A partial list of such diseases is presented in table 3.

Table 3

A PARTIAL LIST OF DISEASES OF IMPORTANCE IN COMMUNICABLE DISEASE CONTROL BUT NOT INCLUDED IN THE MINIMUM LIST FOR NATIONAL REPORTING

A. Infectious Diseases

- | | |
|----------------------------------|--|
| Actinomycosis | Moniliasis |
| Ascariasis | Mononucleosis, infectious |
| Aseptic meningitis | Mumps |
| Blastomycosis | Pediculosis |
| Chickenpox | Pneumonia |
| Coccidioidomycosis | Puerperal sepsis |
| Colorado tick fever | Q fever |
| Conjunctivitis, acute infectious | Rat bite fever |
| Echinococcosis | Relapsing fever |
| Erysipelas | Rheumatic fever, acute |
| Favus | Rickettsialpox |
| Filariasis | Ringworm of the scalp |
| Gas gangrene | Rubella |
| Glanders | Scabies |
| Histoplasmosis | Schistosomiasis |
| Hookworm | Tapeworm infestation |
| Impetigo contagiosa | Trypanosomiasis, American
(Chagas' disease) |
| Influenza | Vincent's infection |
| Keratoconjunctivitis | Vulvovaginitis in children |
| Lymphocytic choriomeningitis | |

B. Noninfectious Diseases

- | | | |
|-----------------------------|---|-----------|
| Dietary deficiency diseases | Metabolic diseases | |
| Beriberi | Diabetes | |
| Pellagra | Goiter | |
| Scurvy | Methemoglobinemia of infants | |
| Rickets | | |
| Toxicological diseases | Complications following various immunization procedures | |
| Barbiturate poisoning | Tetanus following smallpox vaccination | |
| Carbon monoxide poisoning | Paralysis following Pasteur treatment | |
| Lead poisoning | Anaphylactic reactions following egg vaccines | |
| Other | Post-vaccinal encephalitis | |
| Occupational diseases | Miscellaneous | |
| Dermatitis | Accidents | Blindness |
| Silicosis | Cancer | Dog bite |
| Other pulmonary fibroses | Epilepsy | |
| Radiation sickness | Erythroblastosis | |
| | Multiple sclerosis | |
| | Toxemias of pregnancy | |
| | Yaws | |

REVISION OF PUBLIC HEALTH SERVICE "MORBIDITY REPORTING REQUIREMENTS"

The present edition of *Morbidity Reporting Requirements* was issued as of July 1, 1948. The recommendations described here involve several major changes both in the content of the reports and the reporting procedure. It is planned that these changes be instituted on January 1, 1951. Therefore, a revision of the above manual will be prepared and distributed to the States within the next few months.

REPORTING OF EPIDEMICS AND OUTBREAKS

A mechanism will be established by cooperative arrangement between the Public Health Service and the States for the regular weekly reporting of brief narrative accounts of epidemics and outbreaks. Precedents for such a practice already exist in that occasional brief accounts of epidemics have been included in the *Weekly Morbidity Report* and in *Public Health Reports* for many years. These reports, however, have been sporadic and intermittent and have depended upon the chance submission of information from the States.

A more orderly pattern of epidemic reporting has recently been established by the Influenza Information Center of the National Institutes of Health in cooperation with the World Health Organization. The laboratory identifications of influenza and other significant pathogenic agents by the collaborating laboratories were published during the winter of 1949-50 in the *Weekly Communicable Disease Summary*.

The Division of Sanitation, Public Health Service, has employed an independent mechanism for compiling reports on food- and water-borne epidemics from the States. An annual summary of such outbreaks is published separately and is of real interest and value.

The present proposal is felt to be a logical extension of these existing patterns and precedents. Routine epidemic reporting would serve many useful purposes such as:

1. Better control of epidemics.
2. More informative data on the occurrence and distribution of epidemic influenza and other epidemiological entities.
3. Stimulation of better epidemic investigation.
4. Strengthen the national defense against biological warfare.

Discussion of these purposes follows:

1. The traditional purpose of morbidity reporting is the control of epidemics. These become

immediately apparent to the State epidemiologist because when a group of cases is reported to them, geographic localization is evident. Total State figures, however, may mask small but significant outbreaks. For example, if one State reports five cases of typhoid fever, it might indicate either a localized outbreak or a series of unrelated sporadic cases. If it happened to be an outbreak, a brief narrative account would be of interest and importance to health officers of adjoining States. It is entirely possible that single or small clusters of cases in their States might be traceable to the same source. Such epidemiological intelligence would facilitate prompt detection and institution of control of many epidemic diseases.

2. Individual case reporting of influenza is grossly unsatisfactory because the disease cannot be diagnosed clinically and is indistinguishable from many other types of common endemic and epidemic acute respiratory diseases.

Influenza is characteristically an epidemic manifestation covering wide expanses of territory almost simultaneously, and causing a degree of increased morbidity and absenteeism sufficient to become readily apparent to the general public. It is relatively easy for a local health officer to secure a qualitative description of the occurrence and extent of an influenza epidemic in his jurisdiction by telephoning schools and a few major industries to determine, roughly, the extent of increased absenteeism for respiratory disease. If local health officers were instructed to report such events to the State epidemiologist, he in turn could quickly secure a picture for the whole State more promptly and more accurately than he could by the more cumbersome, expensive, and impractical method of individual case reporting.

The only reliable semiquantitative descriptions of epidemic influenza on a national scale have come from analyses of excess weekly influenza-pneumonia deaths and excess total mortality. This source of data is outside the realm of morbidity reporting but the continuance of some mechanism for weekly mortality data is urged. It is believed that a combination of current descriptive reports from health officers with weekly mortality figures would provide a more adequate description of epidemic influenza than is now available.

In addition to influenza, there are a number of other diseases that are characteristically epidemiological entities such as epidemic diarrhea of the newborn, staphylococcus toxin food poison-

ing, and the diarrhea that follows gross sewage contamination of public water supplies. Information regarding the occurrence of these interesting phenomena can only be made available through a system for reporting epidemics.

3. Appropriate editing of these reports should be provided at the State level. If a particular hospital has experienced an epidemic of diarrhea of the newborn the name of the hospital does not need to be publicized, even the city does not need to be mentioned publicly. However, the occurrence of such epidemics is of national interest.

If an epidemic of typhoid fever is traced to a raw milk supply, the dealer need not be named, but the location of the community and the estimated time of the contamination of the supply may well be essential information to epidemiologists and health officers in adjoining areas.

In the reports of food- and water-borne epidemics prepared by the Division of Sanitation of the Public Health Service, certain States such as New York and California appear to have the most outbreaks. This clearly reflects the extent to which such outbreaks are investigated and sources determined, rather than poorer sanitary practices. The willingness of these States to make the information freely available is most commendable and should encourage a similar attitude in all States.

Epidemics of undiagnosed or bizarre diseases or of diseases not now considered reportable occur with considerable frequency. Examples of these are acute contagious gastro-enteritis (so-called "intestinal influenza"), epidemic pleurodynia, impetigo in nurseries, atypical pneumonia, and benign forms of myalgia and meningitis. The provision of an appropriate place where such events could be reported would stimulate interest in these unsolved problems.

4. The subject of defense against biological warfare is still shrouded in the secrecy of security classification. However, it is generally recognized that a potential enemy could create epidemics of a variety of infectious diseases by sabotage or by open warfare.

Biological warfare by sabotage of water or food supplies or by aerial contamination of strategic buildings might produce serious consequences. Adequate defenses against such attacks are difficult to visualize but the importance of "epidemiological intelligence" and the thorough

investigation of all epidemics as they occur are patently necessary.

The proposal for regular reporting of epidemics and outbreaks has, therefore, not only solid justification in the logical development of the peacetime health program but also peculiar significance in the defense of the Nation.

A manual describing in fuller detail the procedures for epidemic reporting is now in preparation at the Communicable Disease Center.

RECOMMENDED MINIMUM CONTENT OF GENERAL MORBIDITY REPORT CARD

Consistent national morbidity data are needed for local, State, and national control of communicable diseases. The adoption by the States of minimum uniformity in certificate content and format contributed greatly to the successful development of mortality and natality statistics.

An individual case report card is necessary for good morbidity reporting. The criteria for selecting the minimum items on the form were: (a) that it include information needed for public health purposes, (b) that consideration be given to the convenience of the private physician and other persons responsible for reporting, and (c) that the content of the report card be as simple and clear in format as possible. In spite of the many advantages of uniform format in a morbidity report card, it is more important at this time to agree on its minimum content. For the purpose of eventually securing agreement on content, a draft of a form is shown (figure 1).

This form contains the following minimum items:

Disease. This item is self-explanatory. The parenthetical note requests type of disease if pertinent or known (for example, poliomyelitis - paralytic, or nonparalytic). If type is not known (when pertinent), the report card should not be delayed until diagnosis is complete. The card should be mailed immediately.

The date of onset is routinely obtained by the attending physician and is needed by the health department for epidemiological appraisal. This data is requested at the present time by 24 States.

Name of Patient. The need for this item is obvious. All except four States now request the name of the patient on general morbidity reports.

Age, sex, and color are basic characteristics needed in evaluation of the incidence and control of disease.

Usual Residence of Patient. The usual residence of the patient is recommended as the most

useful, practical basis for the routine allocation of cases. In addition, usual residence information makes possible the comparison of reported incidence with mortality and population data. Information on place of contraction is important for many diseases, but its correct identification is dependent on careful epidemiological investigation. Data developed in these investigations should be presented as special studies or as supplements to reports of morbidity by usual residence.

Space for Addition of Items by Individual States. Questions pertaining to special problems or interests of individual States should be asked in this space.

Reported by; Address. This item is self-explanatory. Space is also given for checking the need for additional reporting supplies.

The use of envelopes is recommended for all morbidity report cards. They will protect the confidential nature of the report. Also, the reverse side of the card becomes available for the following uses:

1. Provide space for use as an index card in local or State health department. One or two blank horizontal lines across the top of the card on the reverse side would give space for typing

name of patient, area, disease, and other pertinent information.

2. Provide space for the list of legally reportable diseases in the State together with minimum instructions.

3. Provide space for local or State health department use: (a) Stamping date of receipt, (b) recording results of laboratory tests, and (c) recording other supplementary information.

The method of reporting diseases of high frequency such as measles, mumps, and chickenpox requires further consideration. Many private physicians will probably continue to report in round numbers on an individual card. Some such simplified method of reporting the minor diseases would save the physicians time and might encourage better reporting of the more serious diseases.

ADDITIONAL COMMENTS

It should be recognized that national reporting is only the end product of the whole mechanism. Good morbidity reporting depends on strong local health departments and effective stimulation and guidance from the State epidemiologists.

The present recommendations are considered only a first step in fulfilling the 1949 request of the State and Territorial Health Officers rather than a complete solution of the problems.

Figure 1
RECOMMENDED MINIMUM MORBIDITY REPORT FORM

STATE OF			
1. DISEASE (Specify type if pertinent or known)			DATE OF ONSET
2. NAME (First, Middle Initial, Last)		AGE	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female
		RACE OR COLOR <input type="checkbox"/> White <input type="checkbox"/> Non-white	
3. USUAL RESIDENCE	NO., STREET (If rural, give location)		APT. NO.
	CITY OR TOWN	COUNTY	STATE
4. SPACE FOR ADDITION OF ITEMS BY INDIVIDUAL STATES			
5. REPORTED BY		ADDRESS	CHECK FOR SUPPLIES <input type="checkbox"/> Report Cards <input type="checkbox"/> Envps.
NOTIFIABLE DISEASE REPORTS PHS---(VS)			Form approved Budget Bureau No. 68-R097

Actual Size 5½x3¼