



SYRINGE SERVICES BIENNIAL REPORT
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISEASE CONTROL AND FORENSIC PATHOLOGY
SFN 62364 (9-2025)

Agency Information

| | | |
|------------------|------------------|------------------|
| Agency Name | Telephone Number | Reporting Period |
| Agency Contact | Email Address | |
| Physical Address | City | Zip |

Event Totals

| | |
|--|--|
| Number Participants Served | Number of New Participants |
| Approximate Number of Syringes Collected | Number of Syringes Distributed |
| Number of Individuals Referred to Testing Services | Number of Individuals Receiving Testing Services For: HIV Hepatitis Chlamydia/Gonorrhea Syphilis |
| Number of Individuals Who Received HIV/HCV/STD Education | Number of Doses of Naloxone Distributed |
| Number of Condoms Distributed | Number of Individuals Referred to Treatment Services |

Demographic Information—Please report on deduplicated clients served in the reporting period

| | | | | | | |
|---|-----------------------|-----------------|--------------------------------|--------------------|-------|-------------|
| Gender (specify total number served) | | | | | | |
| Male | Female | Unknown | Declined | | | |
| Race (specify total number served) | | | | | | |
| Black/AA | White | AI/AN | Asian | Native Hawaiian/PI | Other | Multiracial |
| Unknown | Declined | Hispanic/Latino | | | | |
| Current Living Status (specify total number served) | | | | | | |
| Permanent | Car/Vehicle | Homeless | Shelter | Declined | Other | |
| Substances Used within Last 30 Days (total number, can be multiple per person) * not as prescribed | | | | | | |
| Heroin | Methamphetamine/Speed | | Crack/Cocaine | | | |
| Methadone (not as prescribed) | Suboxone/Subutex * | | Prescription Pain Medication * | | | |
| Cannabis/Marijuana | Spice | | Other | | | |
| Number of Clients by County of Residence (ND Counties ONLY – list out of state counties by state only) | | | | | | |
| County | Total | County | Total | State | Total | |
| | | | | MN | | |
| | | | | SD | | |
| | | | | | | |

Progress Report

Please enter your sites goals and objectives that were submitted as part of your application process.

| Objective | Target | Current Progress | Progress Narrative |
|-----------|--------|------------------|--------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Report To: This report is to be submitted 15 days after the previous reporting period to remain in compliance with reporting requirements. Failure to do so may result in termination of authorization of the program.

January 1 – June 30
July 1 – December 31

Due: July 15
Due: January 15 of the next year

Email: disease@nd.gov
Fax: 701.328.2499