PhilaVax
Clinic Enrollment Form

DEPARTMENT OF PUBLIC HEALTH

ALL FIELDS ARE REQUIRED, PLEASE PRINT CLEARLY *(Form must be completed for EVERY clinic)*

I. Clinic Information

Clinic Name		
Health System (if applicable)		
Clinic Address		Suite #
City	State	Zip Code
Phone Number	Extension	Fax Number

II. TYPE OF VACCINES ADMINISTERED AT CLINIC (Check all that apply):

☐ Child ☐ Adolescent ☐ Adult ☐ Travel ☐ Influenza Only

III. TYPE OF CLINIC:

☐ Pediatric ☐ Family Practice ☐ Hospital ☐ Pharmacy
☐ Internal Medicine ☐ OB/GYN ☐ Community Health ☐ Other: _____

IV. What method of reporting to PhilaVax is your clinic interested in?

☐ HL7 Messaging

HL7 Version: ☐ 2.5.1 or ☐ 2.3.1

Method:
- ☐ Real-time Bidirectional messaging through SOAP web services
- ☐ Real-time Unidirectional messaging through SOAP web services
- ☐ Batch Unidirectional messaging through SFTP

☐ Electronic – Electronic Health Record (EHR) Flat file
☐ Electronic – Billing data flat file
☐ Clinic does not have an electronic health record or electronic billing system

V. DATA QUALITY:

As part of reporting to PhilaVax, every clinic must identify a staff person responsible for data quality issues within the EHR and PhilaVax. This is generally someone within the clinic.

Name of Clinic Contact (First and Last)		Title
Email Address		
Phone Number	Extension	Fax Number

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FOR ELECTRONIC REPORTING CLINICS ONLY

VI. IT/TECHNICAL SUPPORT

Please list all staff involved in reporting data electronically and their role (e.g. programming, SFTP uploads, etc.)

Contact #1 Name		Title
Company Name		
Email Address		
Phone Number	Extension	Fax Number
Contact #2 Name		Title
Company Name		
Email Address		
Phone Number	Extension	Fax Number:
Contact #3 Name		Title
Company Name		
Email Address		
Phone Number	Extension	Fax Number
Contact #4 Name		Title
Company Name		
Email Address		
Phone Number	Extension	Fax Number

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VIII. ELECTRONIC HEALTH RECORD (EHR) SYSTEM DETAILS

EHR Vendor Name	
EHR Product Name	
EHR Product Version	
Date of Clinic's Last EHR Upgrade	
Date of Next Upgrade (if scheduled)	
EHR Contact Person Name	
EHR Contact Person Title	
EHR Contract Person Phone Number	
EHR Contact Person Email Address	

Please fax this form to: **(215) 238-6944**

Or email to: **PhilaVax@phila.gov**

PhilaVax
Philadelphia's Immunization Information System

PDPH USE ONLY

Date Received: _____

Clinic Code: _____

Provider Code: _____

Entered By: _____

Date Entered: _____