

# PhilaVax

## Clinic Enrollment Form



**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 Contact Person Phone Number	
EHR Contact Person Email Address	

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

Or email to: [PhilaVax@phila.gov](mailto:PhilaVax@phila.gov)



### PDPH USE ONLY

Date Received: \_\_\_\_\_

Clinic Code: \_\_\_\_\_

Provider Code: \_\_\_\_\_

Entered By: \_\_\_\_\_

Date Entered: \_\_\_\_\_