



Provider ID _____

Provider Enrollment Agreement

Clinic Name: _____

Type of Facility: A. Local Health Department D. Indian Health Service Clinic
 B. Private Practice (Individual or Group) E. Other Facility _____
 C. Federally Qualified Health Center / Rural Health Center (FQHC / RHC)

Contact Person: _____
First Name Last Name TitlePhysical Address: _____
Street Only (No P.O. Boxes)

City State Zip

Mailing Address: _____
Street or PO Box

City State Zip

Email Address: _____

Telephone: () _____ Extension _____ Fax: () _____

PART I: Provider Agreement

The Utah Statewide Immunization Information System (USIIS) is a confidential computerized immunization registry and tracking system operated and maintained by the Utah Department of Health (UDOH) and available as a single data source for all community partners. It is a tool to aid health care providers by sharing patient immunization information. USIIS is only available to authorized users and the UDOH. Immunization records will be included in USIIS unless individuals or parents/guardians withdraw.

USIIS is developed under the authority of the following provisions of the Utah Code: Title 26, Chapter 3, Health Statistics; Title 26, Chapter 6, Communicable Diseases Control Act, Section 26-1-17.5; Title 53A, Chapter 11, Part 3, Immunization of Students; and Utah Administrative Rule R386-800 Immunization Coordination.

As a condition of participating in USIIS, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, community clinic, health department, or other health care delivery facility of which I am the physician-in-chief, health officer, facility director, or equivalent:

1. I will use USIIS only for the receipt and input of patient or vaccine information.
2. I will access USIIS only when needed to assure adequate immunization of a patient, to avoid unnecessary immunizations, to confirm compliance with mandatory immunization requirements, and to control disease outbreaks.
3. I understand the USIIS service and related data is the property of the Utah Department of Health (UDOH). The UDOH retains all rights in USIIS and grants the Provider a non-exclusive license to use the service. Any use, unauthorized disclosure, or dissemination of confidential information is in violation of the Confidentiality and Security Policy and may result in significant criminal or civil penalties.
4. I will ensure staff safeguards their issued USIIS user ID and password against use other than allowed by the User Confidentiality and Security Agreement. I understand that I am responsible for the actions of staff regarding the confidentiality of information contained in the registry system.

Provider Agreement (continued)

5. I will immediately notify the Utah Immunization Program of any unauthorized use or disclosure of, or any unauthorized access, or any theft or loss of data I suspect or that comes to my attention.
6. I will notify the Utah Immunization Program when a user terminates employment so that the user can be removed from USIIS and maintain the confidentiality and security of the registry.
7. I will cooperate with the UDOH in notifying individuals or parents/guardians about the USIIS system and provide information about their right to withdraw from the system. Contact information will be available to individuals and parents/guardians who wish to withdraw. The UDOH is responsible for withdrawing the child or individual from USIIS.
8. I will provide USIIS with demographic and immunization information about patients receiving vaccinations in the clinic(s). I will submit all immunization information (historical and/or current) to USIIS promptly after obtaining it.
9. I will allow parents/guardians to inspect, copy, and if necessary, amend or correct their child's immunization record if he/she demonstrates that record is incorrect. The corrected information shall be entered into USIIS or a local database and sent to USIIS via a data upload.
10. I will not sub-license, distribute, sell, supply, modify, adapt, amend, incorporate, merge or otherwise alter the USIIS web-based service. I will not attempt to decompile, reverse engineer, otherwise disassemble or attempt to derive any source code relating to the USIIS service.
11. UDOH may terminate all current and future access to USIIS at any time for failure to comply with these requirements. Or, I may terminate this agreement at any time.

Signature of physician-in-chief, health officer, or equivalent	Print Name	Date
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PART II: User Information

Please PRINT clearly or TYPE the names and title of all staff that require access to USIIS.

Clinic USIIS Users:

First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)

User Information (continued)

First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)
First Name	MI	Last Name	Title	Vaccinator (Y / N)

This record is to be submitted to and kept on file with the Utah Department of Health Immunization Program, and must be updated every two years.

The original form must be mailed; no faxed copies will be accepted.

Please Mail Form to:

**Utah Department of Health
Immunization Program
PO Box 142001
Salt Lake City, UT 84114-2001
Phone: (801) 538-9450**

PROGRAM USE ONLY

Date Received: _____

- Type of Facility: Private Practice (Individual or Group)
 Local Health Department
 FQHC / RHC
 Other Public Program
 Indian Health Service

Approved: _____
(Signature)

Date: _____

Entry Date: _____

Entry By: _____
(Signature)