



PROVIDER SITE ENROLLMENT AGREEMENT

State Form 52306 (R2 / 7-13)

INDIANA STATE DEPARTMENT OF HEALTH, IMMUNIZATION PROGRAM

Internal Use Only

IRMS

Facility

Online Date

- INSTRUCTIONS:**
1. Complete this form.
 2. Return both pages via fax to (317) 233-8827 or mail to:
 3. Immunization Dept.; 2 North Meridian Street, Section 6A, Indianapolis, IN 46204

PROVIDER SITE ENROLLMENT

To participate in the Children and Hoosiers Immunization Registry (*CHIRP*)

CHIRP is an Internet-based immunization registry operated by the Immunization Program of the Indiana State Department of Health (*ISDH*). Enrolled health care providers can obtain immunization information for patients, including tracking and recall. Patient information is confidential and only available to the authorized users.

The immunization records of all children and adults in Indiana may be included in the system without consent. An individual, parent or guardian may withdraw their information from CHIRP at any time. Participation in CHIRP is voluntary. CHIRP is developed under the authority of Indiana Code §16-38-5.

As a condition of participating in CHIRP, the above Provider enters into this agreement with the Indiana State Department of Health, and agrees to the following:

- To use CHIRP only for the immunization needs of patients. The Provider and his or her staff will access the registry
 - o to assure adequate immunization,
 - o to avoid unnecessary immunizations,
 - o to confirm compliance with mandatory immunization requirements,
 - o to control disease outbreaks, or
 - o to conduct ongoing or special immunization coverage assessments.
- If this agreement is violated by any use of the system in an unauthorized manner, ISDH reserves the right to terminate access to the system.
- The Provider shall abide by the requirements in Attachment A, CHIRP Confidentiality Agreement, which is incorporated by reference into this agreement. Each staff member needing access to CHIRP must sign the Individual User Agreement and Confidentiality Statement, which must be kept in the employee's Personnel File.
- The Provider acknowledges that unauthorized disclosure of confidential information may result in civil penalties. The Provider will take all reasonable steps to assure employee compliance with confidentiality requirements.
- The Provider shall cooperate with ISDH in notifying parents or guardians about the system. Brochures and posters will be available at no cost to the Provider.
- The Provider shall furnish specified demographic and immunization information about patients receiving immunizations promptly, striving for submission within one week after immunization administration.
- The Provider shall allow the parents or guardians to inspect, copy, and if necessary, amend or correct their own children's immunization records if he/she demonstrates that such records are incorrect. This corrected information shall be entered into CHIRP or a local database and sent to CHIRP.

PROVIDER SITE ENROLLMENT (To participate in the Children and Hoosiers Immunization Registry)

Name of the Organization: _____

Organization Type: Private Practice Public Clinic Public School Private School
 Hospital Child Care Center* Head Start* Long-Term Care
 Pharmacy
 Other: _____

How many clinical sites do you have? _____

Will additional clinical sites be submitting enrollments? ☐ YES ☐ NO ☐ N/A

How will you be submitting data to CHIRP: ☐ Direct Data Entry ☒ Electronic Import

Is this Clinical Site a VFC (*Vaccine for Children*) provider? ☐ YES ☐ NO PIN # _____

Clinical Site Name: _____

Clinical Site Address: _____

Clinical Site Contact: _____

Telephone: _____ County: _____

FAX: _____ E-Mail: _____

*Licensed Child Care Centers and Licensed Head Start Centers only.

Signing this form signifies that you are in agreement with the items outlined on page one of this form. Please sign, keep a copy for yourself, and fax the form to 317-233-8827 or mail the original to the Indiana Department of Health, Immunization Program #6A-22, 2 N. Meridian St., Indianapolis, IN 46204

Signature of Provider or Authorized Representative

Date (month, day, year)

Printed Name and Title Authorized Representative

Date (month, day, year)