



**Private Providers Interested in Participating in the
Pennsylvania Statewide Immunization Information System
(PA-SIIS)**

(Please Print)

Facility Name: _____

Contact Name: _____

Contact Title: _____

Address 1: _____

Address 2: _____

City: _____

State: _____

Zip Code: _____

County: _____

Phone: _____

Fax: _____

Email: _____

Electronic Medical
Record Vendor: _____

1. Select Meaningful Use stage (if applicable):

Stage 1 Stage 2 Stage 3

2. Select the access type:

HL7 Interface Web Application

3. Does the provider administer immunizations?

Yes No

4. Provider Specialty (Select all that apply):

Pediatrics General Practice
 Family Practice Other (specify) _____

Form completed by: _____ Date: _____

Please <u>fax</u> completed form to: PA-SIIS 717-772-3258	or <u>mail</u> completed form to: PA-SIIS PA Department of Health Bureau of Health Statistics and Research 555 Walnut Street, 6th Floor Harrisburg, PA 17101
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