**Request for COVID-19 Patient Status**

Request ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For DOH Use Only**

**By Government Agencies**

This form is intended for use only by a government agency that is managing a patient waiting lists or assisting special populations in scheduling appointments for COVID-19 vaccinations.

|  |
| --- |
| **GOVERNMENT AGENCY’S INFORMATION** |
| **Government Agency’s Name:**  | Click or tap here to enter text. |
| **Address:** | Click or tap here to enter text. |
| **Contact Name:** | Click or tap here to enter text. |
| **Contact Email address:** | Click or tap here to enter text. |
| **Contact Phone number:** | Click or tap here to enter text. |
| **Indicate Desired Frequency:** | [ ] One-Time[ ] Weekly |
| **PATIENT FILE FORMAT REQUIREMENTS** |
| Once your application has been approved, you will be instructed to transmit a patient file via secure email protocol or SFTP/FTP. **Do not send your file until we have instructed you to do so.** No more than 1 million patients can be included in a file. In addition, the file must meet the following requirements:* Tab-Delimited Text File
* Fields with the following field headers listed in the order shown below
	+ First\_name
	+ Last\_name
	+ DOB – Date of Birth must be formatted as MM/DD/YYYY
	+ ZIP – Only include first 5 digits of zip code
	+ Case\_Number – Unique patient identifier. DO NOT use a social security number.
 |
| **RETURNED PA-SIIS DATA** |
| Please note that all fields provided in the tab-delimited text file are used as part of the exact matching process. Due to the limited data being used for this matching process, it is possible for a false positive to occur. The following patient information will be returned to you via secure email or SFTP/FTP protocol:* All fields in your file
* Status Indicator of Yes or No
	+ A “Yes” value will be returned for ***exact matches only***.
 |
| **GOVERNMENT AGENCY’S AUTHORIZED REPRESENTATIVE**  |
| My signature below attests that I am an authorized representative of this government agency and that I am requesting this information to support the business needs of this government agency. I understand that information in Pennsylvania’s Immunization Regitry is protected health information under the Disease Prevention and Control Law, Title 28, Chapter 27 Communicable and Noncommunicable Disease Regulations.  |
| **Name:** | Click or tap here to enter text. |
| **Title:** | Click or tap here to enter text. |
| **Signature:** |  |
| **Date:** | Click or tap here to enter text. |

**Submit this completed form to the following:**

Pa. Department of Health

Bureau of Health Statistics and Registries

Immunization Registry

Email: RA-DHPASIIS-DATA@pa.gov

Fax: 717-213-6936