Date processed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For DOH Use Only**

**Request to Transmit Vaccination Data via HL7 to PA-SIIS**

This form is to be used by facilities who have been approved for a PA-SIIS clinic to transmit patient vaccination information via HL7 to the Pennsylvania Statewide Immunization Information System (PA-SIIS). To be considered for integration through HL7, the facility must be submitting HL7 based on national standards as adopted by the Bureau of Health Statistics and Registries (BHSR).

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| **APPLICANT INFORMATION** | | | |
| **PA-SIIS clinic ID:** | Click or tap here to enter text. | | |
| **Facility name:** | Click or tap here to enter text. | | |
| **Facility address:** | Click or tap here to enter text. | | |
| **Facility HL7 coordinator contact information:** | | | |
| **Name:** | | Click or tap here to enter text. | |
| **Title:** | | Click or tap here to enter text. | |
| **Email address:** | | Click or tap here to enter text. | |
| **Phone number:** | | Click or tap here to enter text. | |
| **SOFTWARE INFORMATION** | | | |
| **EMR/software product** (name and version): | | Click or tap here to enter text. | |
| **HL7 Transmittal Method:** | | **Point-to-Point Directly from EMR/software product**  **PA Public Health Gateway – Enter HIE Name:** Click or tap here to enter text.  **Midware Used to Transmit HL7** | |
|  | | **Software/Product:** | Click or tap here to enter text. |
|  | | **Company Name:** | Click or tap here to enter text. |
|  | | **Account Contact:** | Click or tap here to enter text. |
|  | | **Email address:** | Click or tap here to enter text. |
|  | | **Phone number** | Click or tap here to enter text. |
| **ONBOARDING AND REPORTING REQUIREMENTS** | | | |
| * Facility shall become familiar with the HL7 standards published at <https://www.health.pa.gov/topics/Reporting-Registries/PA-SIIS/Pages/HL7.aspx>. * Facility shall test HL7 messaging against [PA-SIIS NIST tool](https://hl7v2.gvt.nist.gov/gvt/#/home). * Upon receipt of the credentials for HL7 testing in PA-SIIS UAT environment, the facility shall [establish connectivity](https://www.health.pa.gov/topics/Documents/Reporting-Registries/SIIS/PA-SIIS%20HL7%20Connectivity.docx) and then test the required scenarios once NIST test results are sound. * Upon successful transmittal and self-verification of HL7 testing scenarios, the facility shall contact BHSR at [ra-dhPASIIS@pa.gov](mailto:ra-dhPASIIS@pa.gov) or by phone at requesting a second set of HL7 test scenarios which BHSR will validate after transmittal by the facility. BHSR will coordinate a date/time for this test to take place. * Upon successful testing in PA-SIIS UAT environment, BHSR will provide the facility with credentials for PA-SIIS production. * Upon promotion to PA-SIIS production environment, BHSR will establish a go-live date for he facility to begin transmitting HL7 data. The facility will actively self-audit as follows: * The first 10 VXU messages transmitted -- If any issues are identified during the self-audit, the facility will immediately halt transmitting any further VXU messages until the issue is identified and resolved. In addition, the facility will notify BHSR of its findings. If no issues are identified, the facility may continue transmitting VXU messages through HL7. * The facility will self-audit 25 random VXU messages transmitted during the first week of production. If the facility transmits less than 25 messages during the week, then the facility shall expand the duration of this test to the next week(s). * During weeks 2 to 4 of self-monitoring, the facility will provide BHSR with the total number of VXU messages transmitted for the previous week. BHSR will conduct a random sampling of VXU messages for auditing purposes. This random sampling will consist of a minimum of 50 VXU messages or up to 10 percent of all VXU messages transmitted (whichever is lower). | | | |

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| **AUTHORIZED REPRESENTATIVE OF THE FACILITY**  **An authorized representative of the facility must sign the assurance statement listed below stating that the facility agrees to the onboarding and reporting requirements listed above.** | |
| My signature below attests that I am an authorized representative of this facility and that the information I have provided on this form is true and correct to the best of my knowledge. I have thoroughly reviewed and will adhere to the requirements set forth therein.  I understand that information in PA-SIIS is protected health information under the Health Insurance Portability and Accountability Act (HIPAA), Privacy Rule 45 CFR 164.512(b), and 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-HL7@pa.gov](mailto:ra-dhPASIIS-HL7@pa.gov)

Fax: 717-213-6936