USIIS ID

USIIS Provider Facility Enrollment Agreement

FACILITY INFORMATION (All information is required.)		
Facility Name:		
Facility Address:		
City:	State:	Zip Code:
Telephone:	Fax:	
Mailing Address (*if different*):		
City:	State:	Zip Code:
Facility Contact & EHR System Information (All information is required.)		
USIIS Facility Contact:		
Facility Contact's Work Email Address:		
Electronic Health Record (EHR) system and vendor:		

FACILITY TYPE (Select facility type.)

Private Facility Types	Public Facility Types
❑ Private Hospital	❑ Local Health Department Clinic
❑ Private Practice (solo/group/HMO)	❑ Public Hospital
❑ Private Community Health Center	❑ FQHC/RHC
❑ Pharmacy	❑ Public Community Health Center
❑ Private School-Based Clinic	❑ Public School-Based Clinic
❑ Assisted Living /Nursing/Long-term Care	❑ Tribal/Indian Health Services Clinic
❑ Home Health Care	❑ State Health Clinic
❑ Hospice Care	❑ Juvenile Detention Center
❑ Other: _____	❑ Correctional Facility

VACCINES FOR CHILDREN PROGRAM (VFC)

Enrolling in the VFC Program: Yes No

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official registered health care provider signing the agreement must be a practitioner authorized to administer vaccines under Utah state law who will also be held accountable for compliance by the entire organization with the conditions outlined in the provider agreement. The individual listed here must sign the provider agreement.*

Last Name, First, MI:	
Title:	License No.:

PROVIDER AGREEMENT

To participate in and receive access to USIIS, I agree to the following conditions on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or equivalent:

The Utah Statewide Immunization Information System (USIIS) is a confidential computerized immunization information system operated and maintained by the Utah Department of Health (UDOH). It is a tool to aid health careproviders and community partners by sharing Utah residents' immunization information. USIIS is only available to authorized users. 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 required by Section 63-46a-3(5), any person who violates any provision of the rule may be assessed a civil money penalty as provided in Section 26-23-6.

As a condition of participating in USIIS, I agree to the following conditions on behalf of myself and all the staff associated with this health care delivery facility of which I am the medical director, facility director, or equivalent:

1.	I will use USIIS only for the submission and access of patient or vaccination information.
2.	I will access USIIS only when needed to assure adequate immunization of a patient, to avoid unnecessary immunizations, to confirm compliance with immunization recommendations, and to control disease outbreaks.
3.	I understand the USIIS service and related data is the property of the Utah Department of Health and Human Services (DHHS). The Utah DHHS retains all rights in USIIS and grants the Provider a non-exclusive license to use the service.
4.	I have read and will adhere to the requirements of the USIIS Confidentiality and Security Policy.
5.	I will ensure staff safeguard their issued USIIS usernames and passwords against use other than allowed by the USIIS User Confidentiality and Security Agreement. I understand that I am responsible for the actions of staff regarding the confidentiality of information contained in the system. 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.
6.	I will immediately notify the Utah USIIS 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.
7.	I will notify the Utah USIIS Program when a user terminates employment so that the user's access can be removed, thereby maintaining the confidentiality and security of the system.
8.	I will provide USIIS with demographic and immunization information about patients receiving vaccinations in the facility. I will submit all immunization information (historical non-administered and/or administered) 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 system and sent to USIIS via a data interface.
10.	I will cooperate with the Utah DHHS in notifying individuals or parents/guardians about the USIIS system and provide information about their right to withdraw from the system. Information will be available to individuals and parents/guardians who wish to withdraw. The Utah DHHS is responsible for withdrawing the child or individual from USIIS.
11.	I will not sub-license, distribute, sell, supply, modify, adapt, amend, incorporate, merge or otherwise alter the USIIS web-based system. I will not attempt to decompile, reverse engineer, otherwise disassemble or attempt to derive any source code relating to the USIIS service.

By signing this form, I certify on behalf of myself and all staff in this facility, I have read and agree to the USIIS enrollment conditions listed above and understand I am accountable for compliance with these conditions.	
Medical Director or Equivalent Name (print):	
Signature:	Date:

This record is to be submitted to and kept on file with the Utah Department of Health USIIS Program.

A copy of this completed document is considered the same as the original.

Send emailed form to: **usiistracking@utah.gov**

Utah USIIS Program Use Only Date received: _____

Facility Type: Local Health Dept. ❑ Private ❑ FQHC/RHC ❑ Hospital Pharmacy Other Public

Approved By:_____Date:_____UCMS Date: _____