Become an Influenza Sentinel Provider

Please complete the form below to sign up as an Influenza Sentinel Provider or Laboratory Sentinel Site. You may fax this form to 217-524-0962 or email this information to dph.influenza@illinois.gov. If you have questions, please call the influenza program at 217-782-2016.

Are you interested in participating in the Provider ILINet Program, the Laboratory Program, or Both?

____ Provider ILINet Program  _____ Laboratory Program  _____ Both

(If participating in both programs, please complete all sections below. If only participating in one program, complete the appropriate section below.)

Are you interested in seasonal or year-round participation?

_____ Seasonal Participation (week 40 through week 20)  _____ Year-round Participation

Practice/Facility Name: ________________________________________________________________

Practice Type:  

○ Family Practice  ○ Student Health  ○ Pediatrics
○ Emergency Medicine  ○ Internal Medicine  ○ Urgent Care
○ Infectious Disease  ○ Other _______________________________________

Facility Address: ___________________________________________________________________

City and Zip: _______________________________________________________________________

Fax Number: _______________________________________________________________________

ILINet Contact Name: ____________________________ Phone: ____________________________

Title: __________________________________________________________________________

Alternate Contact Person: ____________________________ Phone: __________________________

Title: __________________________________________________________________________

Email Address: ____________________________________________________________________

Alternate Email Address: ___________________________________________________________

Lab Contact Name: ____________________________ Phone: ____________________________

Title: __________________________________________________________________________

Email Address: ____________________________________________________________________

Additional Comments or Questions: ____________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

For IDPH Use Only:

Provider ID: ______________________

Date Started: _____________________