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.)

Practice/Facility Name: _________________________________________________________________

Practice Type:  

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

Facility Address: _______________________________________________________________________

City and Zip: __________________________________________________________________________

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: ______________________