



- INSTRUCTIONS:**
1. Complete this form.
  2. Return both pages via fax to 217-524-0967 or mail to:
  3. Immunization Section, 525 West Jefferson, Springfield, IL 62761

## **PROVIDER SITE ENROLLMENT**

To participate in the Immunization Data Registry known as  
Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE)

The I-CARE Registry (Registry) is an electronic web-based immunization data registry operated by the Illinois Department of Public Health (IDPH) as authorized by the Immunization Data Registry Act, 410 ILCS 527. The Registry is accessible only to enrolled users who have predefined roles. Enrolled health providers can submit and obtain immunization information for patients, including tracking and recall. Patient information is confidential and only available to authorized users.

The immunization records all children and adults in Illinois may be included in the Registry without consent. An individual, parent, or legal custodian may have a client's record excluded from the Registry at any time by completing the Illinois' Immunization Registry Opt-Out Form. Participation in the Registry is voluntary.

As a condition of participating in the Registry, the Provider enters into this Agreement with the Illinois Department of Public Health (IDPH), and agrees to the following:

- To use the Registry only for immunization needs of patients. The Provider and his/her staff will access the Registry
  - To assure adequate immunization,
  - To avoid unnecessary immunizations,
  - To confirm compliance with mandatory immunization requirements,
  - To conduct ongoing or special immunization coverage assessments, or
  - To accomplish other public health purposes as determined by IDPH.
- If this agreement is violated by any use of the Registry in an unauthorized manner, IDPH reserves the right to terminate access to the Registry.
- The Provider shall abide by the requirements in Attachment A, I-CARE Confidentiality Agreement, which is incorporated by reference in this agreement. Each staff member needing access to the Registry must sign the Individual User Agreement and Confidentiality Statement, which must be kept in the employee's personnel file.
- The Provider acknowledges that unauthorized disclosure of confidential information may result in civil penalties. The Provider will take reasonable steps to assure employee compliance with confidentiality requirements.
- The Provider shall furnish specified demographic and immunization information about patients receiving immunizations promptly, striving for submission within one week after immunization administration.

**PROVIDER SITE ENROLLMENT**

*(To participate in the Illinois Comprehensive Automated Immunization Registry)*

Name of the Organization \_\_\_\_\_

Organization Type:     Local Health Department                       Child-Placing Agency  
                                  Elementary or Secondary School                       Child Care Center  
                                  Health Care Provider                                       College/University  
                                 Please specify type of provider \_\_\_\_\_

How many clinical sites do you have? \_\_\_\_\_

Will additional clinical sites be submitting enrollments?     YES     NO     N/A

How will you be submitting data to I-CARE:     Direct Data Entry     Electronic Import

Is this Clinical Site a VFC (*Vaccine for Children*) provider?     YES     NO    PIN # \_\_\_\_\_

Clinical Site Name: \_\_\_\_\_

Clinical Site Address: \_\_\_\_\_  
\_\_\_\_\_

Clinical Site Contact: \_\_\_\_\_

Phone: \_\_\_\_\_                      County: \_\_\_\_\_

FAX: \_\_\_\_\_                      E-Mail: \_\_\_\_\_

Signing this form signifies that you are in agreement with the items outlined on page one of this form. Please sign, keep a copy for yourself, and fax the form to 217.524.0967 or mail the original to the Illinois Department of Public Health, Immunization Program, 525 W Jefferson St FL1, Springfield, IL. 62761 or scan the document and e-mail as an attachment to [DPH.ICARE@illinois.gov](mailto:DPH.ICARE@illinois.gov)

\_\_\_\_\_  
Signature of Provider or Authorized Representative                      Date

\_\_\_\_\_  
Printed Name and Title Authorized Representative                      Date