ADHS

ASIIS Enrollment Application

DIRECTIONS: Please complete and submit this form to ASIISHelpDesk@azdhs.gov

Organization Name: _____

Physical Address: _____

City: _____ State:_____ Zip: _____ County_____

Phone #: (_____)_____ FAX #: (_____) _____

Organization Main Contact: _____

E-mail address: _____

Mailing Address: _____

City: _____ State:_____ Zip: _____ County_____

Please report all facility information on page 2.

Type of Organization: (**Select only one**)	Family or General Practice Pediatrics Practice Family Health Center School-Based Clinic or Family Resource and Wellness Center Indian Health Service Unit (IHS/Tribal Health Center) County Health Department Private Hospital Public Hospital Community Health Center (FQHC) Rural Health Center (RHC) Other (please specify)_____

Please contact ASIISHelpDesk@azdhs.gov if you have any questions.

<u>Facility #1</u>

Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County _____

Phone #: (_____)_____ FAX #: (_____) _____

Facility Contact: _____

E-mail address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County _____

<u>Facility #2</u>

Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County _____

Phone #: (_____)_____ FAX #: (_____) _____

Facility Contact: _____

E-mail address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County _____

<u>Facility #3</u>

Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County _____

Phone #: (_____)_____ FAX #: (_____) _____

Facility Contact: _____

E-mail address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County _____

<u>Facility #4</u>

Name: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ County _____

Phone #: (_____)_____ FAX #: (_____) _____

Facility Contact: _____

E-mail address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County _____

ADHS

Arizona State Immunization Information System (ASIIS) User Information

Organization Name: _____

Facility Name: _____

The following methods will be used to report immunization information to the ASIIS Registry:

Web Application (Direct access to the registry via the Internet)
Electronic Medical Record (EMR) via HL7 v2.5.1

Name of PMS/EMR: _____ Name of Vendor: _____

Please list the full name, email and select a user privilege for each staff members who will use the web application.
- View Privilege means you can only look at the patient record and immunization record.
- Edit Privilege means you can view, add and make changes to patient and immunization record.

Name	Email Address	Privilege	
		View	Edit
		View	Edit
		View	Edit
		View	Edit
		View	Edit
		View	Edit
		View	Edit
		View	Edit

All Users shall electronically accept the terms of the Pledge to Protect Confidential Information on their first login.

Please contact ASIISHelpDesk@azdhs.gov if you have any questions.

ASIIS is a computer based immunization registry and tracking system implemented by the Arizona Department of Health Services and its partners. It is intended to aid health care professionals and other users who have a need to check a client's immunization status according to A.R.S § 36-135, R9-6-707, and R9-6-708. Through ASIIS, providers can place orders for publicly funded vaccines to provide to children eligible to receive VFC vaccines. Client-specific information and vaccine ordering privileges are only available to authorized users and the Arizona Department of Health Services. The Users enters into this agreement with the Arizona Department of Health Services and agree to adhere to all requirements that are listed in the Pledge to Protect Confidential Information.