

Office/Facility Enrollment Form

Please fill out this form in its entirety. This information is used to establish a Kentucky Immunization Registry account for your organization. If you have questions regarding this form, please contact the KYIR Help Desk at (502)564-0038 or KYIRHelpdesk@ky.gov.

Provider (Practice/ Facility) Name: _____

National Provider Identifier (NPI): _____

Provider Mailing Address: _____

City _____ County _____ State _____ Zip Code _____

Provider Contact Person: _____

Title: _____

Business Phone _____

Fax #: _____

E-mail address: _____

Provider Type: (check only one)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Community Health Center | <input type="checkbox"/> School/School District |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> General Practice | <input type="checkbox"/> Health Care Org./Ins. Co. | <input type="checkbox"/> FQHC |
| <input type="checkbox"/> Local Health Dept | <input type="checkbox"/> Urgent Care | <input type="checkbox"/> Non-Profit/Free Clinic | <input type="checkbox"/> Nursing Home/Hospice |
| <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Rural Health Clinic | <input type="checkbox"/> Child and Family Services | <input type="checkbox"/> Other: _____ |

Does your office give immunizations? Y N

HL7 Status (check all that apply)

Have an EMR in the Clinic EMR is on-board with KHIE Note: _____

Usage Type: (check all that apply)

- Managed Care / HEDIS (can only upload & retrieve data for HEDIS reporting)
- Research Immunization Records (view only)
- Manually Enter Newly Administered and/or Historical Immunizations
- Vaccines for Children Program (VFC), 317 adult program, and COVID providers only- Full Inventory Management
- These providers must track manufacturers/lot numbers for vaccines in KYIR and manage the quantities of vaccines in stock

Does your provider/facility participate in any of the following programs? (check only if enrolled or currently enrolling)

| | | |
|-----------------|--------------------------------------|--------------------|
| VFC Provider? | If yes...VFC Effective Date? _____ | VFC Pin #? _____ |
| 317 Provider? | If yes...317 Effective Date? _____ | 317 Pin #? _____ |
| COVID Provider? | If yes...COVID Effective Date? _____ | COVID Pin #? _____ |

What Vaccine Funding Sources Does your Clinic Administer? (please check all that apply)

VFC 317 State Private COVID Other: _____

