Meaningful Use (MU)
Immunization Registration of Intent

* Required Information

***Registering as:** ____ Eligible Hospital ___ Eligible Provider(s)
***Facility Name:** ____
A single registration is completed for each location and may include multiple eligible providers
***Facility Address**:____
***Facility City/zip**:____
***State Supplied Vaccine (SSV) ID**: ________
***KIDSNET ID(s):** _________

*Eligible Provider (EP) name	*EP license number

Include eligible providers (EPs) that administer vaccine to <19 year olds at this facility. Attach additional names if needed. Please make sure that eligible providers are also listed on the Licensed Vaccine Provider List of the State Supplied Vaccine (SSV) enrollment.

***Primary Practice Contact**: ____
This person will receive all official communications.
***Primary Practice Contact Phone**:____
***Primary Contact Email:**____
***Primary Technical Contact**: ____
***Primary Technical Contact Phone**: _______________________________________
***Primary Technical Contact Email**: _______________________________________

***MU Reporting Period Start Date**: _________________ **End Date:**____________________
***MU Stage**:_______________

***Electronic Health Record (EHR)Vendor**:_____________________________________
***EHR Vender Contact**:____
***EHR Vender Contact Telephone:**____
***EHR Vender Contact E-mail**:____
***EHR Product and Version**:____
HL7 Version used: ____
Note: HL7 2.5.1 will be required for any Practice who does not have ongoing submission to KIDSNET Production prior to their Stage 2 reporting period.
Certified EHR Number____
Intended Transport: _____SOAP _____HTTPS post

E-mail completed form to jeff.goggin@health.ri.gov
All practices/providers are required to maintain reporting to **KIDSNET production** while testing.