

IMPACT SIIS

Statewide Immunization Information System

Registration Information

This registration must be completed and the Security Agreement (on the back) signed and returned before the practice/provider can participate in the IMPACT SIIS registry and login to the www.IMPACTSIIS.org.

Facility Name: _____

Address: _____

City _____, Ohio Zip _____

Return by mail only to **(NO FAXES):**
Ohio Department of Health
Immunization Program-Impact SIIS
35 East Chestnut Street, 6th Floor
Columbus, Ohio 43215

Designate the primary contact person at the practice who will be granted the highest security level of "Key Master" on the system. The Key Master is the liaison to the Impact SIIS staff and is responsible for:

- ✓ Entering into the system the authorized users at the practice, establishing separate user names, passwords, and security level access for each
- ✓ Ensuring the authorized users all agree to, and abide by, the Security Agreement
- ✓ After obtaining training following initial registration, teaching the system to newly authorized users
- ✓ Entering into the system any separate clinic sites operated by the practice (if applicable)
- ✓ Establishing the default settings for the practice in the system (these save time and keystrokes)

Contact Person (Key Master): _____

User ID Preference: _____ Telephone Number: (____)____-_____

Fax Number: (____)____ E-Mail Address: _____@_____

Best Day and Time to Contact: Mon Tues Wed Thurs Fri

Facility Federal Tax ID: _____ Facility NPI#: _____

Facility Medicaid #: _____

(This is the main number used to bill Medicaid for the administration of vaccines.)

Enter each physicians' and nurse practitioners' names, Ohio Medical License & NPI Numbers:

Provider Name	Medical License #	Medicaid #	Provider NPI #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<p>Practice Management or Billing System Information</p> <p>Company _____</p> <p>Product _____ Version _____</p> <p>Contact _____</p> <p>Contact Phone (____)____-_____</p> <p>Contact Email _____</p>	<p>Electronic Medical Record (EMR)/Electronic Health Record (EHR) Information</p> <p>Company _____</p> <p>Product _____ Version _____</p> <p>Contact _____</p> <p>Contact Phone (____)____-_____</p> <p>Contact Email _____</p>
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Do not forget to have the legally responsible Physician or Management level personnel at the practice/facility sign the Security Agreement (on back) and retain a copy for your records.