# HL7 Application Form

Please note: **This form should only be completed if your office administers immunizations**. If your office does **not** administer immunizations, you do not need to report any data to Nevada WebIZ and you are exempt from the Meaningful Use IIS menu item. Visit the Center for Medicare & Medicaid EHR Incentive Program website at www.cms.gov/EHRIncentivePrograms for more information.

If your office administers immunizations, are you enrolled in Nevada WebIZ? *(circle one)* **YES** or **NO**

If "**NO**" please complete the Nevada WebIZ Enrollment Form, located at:
http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/WebIZ/Docs/WebIZ%20Enrollment%20Form201408.pdf

**PRACTICE INFORMATION** *(please print clearly)*

Practice Name: _____

Type of Practice: *(circle one)* **General Practice** **Hospital** **Pediatrics**
**Pharmacy** **Urgent Care** **Other:** _____

Number of practice locations offering vaccines: _____ Number of vaccines given annually: _____

Names of all practice locations that offer vaccines *(attach separate sheet if necessary)*:

_____

_____

_____

**CONTACT INFORMATION** *(please print clearly)*

Contact Name: _____

Title: _____

Phone: _____ Fax: _____

Email: _____

# HL7 Application Form

**Electronic Medical/Health Record (EMR/EHR) System**

Name of EMR/EHR software used by your practice: _____

Name of EMR/EHR vendor (software company): _____

Is your EMR/EHR equipped to use HL7 version 2.5.1? *(circle one)* **YES** or **NO**
*(If unsure, contact your EMR/EHR vendor)*

Who will build your HL7 interface? *(circle one)* **Onsite IT Personnel** or **EMR/EHR Vendor**

**EHR Incentive Program ("Meaningful Use")**

☐ Check this box to *Declare Your Intent* to electronically submit immunization data to Nevada WebIZ (statewide IIS) via HL7 messages.

***If attesting as an Eligible Professional…***
List all Eligible Professionals, including NPI, registering their intent at this/these location(s). (If there are more than 4 professionals, we will collect this information later.)

| EP Name | NPI |
|---|---|
| | |
| | |
| | |
| | |

List the NPI for each practice location. (If there are more than 4 locations we will collect this information later)

| Practice Name | NPI |
|---|---|
| | |
| | |
| | |
| | |

***If attesting as an Eligible Hospital…***
List hospital name and NPI, registering intent.

| EH Name | NPI |
|---|---|
| | |
| | |

**Please submit form by fax: (775) 687-7596 or email: jlammers@health.nv.gov.**