Ohio Outpatient Influenza-Like Illness Provider Enrollment Form

Please fill out the following information if you are interested in participating as a sentinel provider in the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet).

Person Responsible for Surveillance at Site: __________________________________________________________ (first and last name and title)

Primary Contact (person will who report each week): ____________________________________________________ (first and last name and title)

Practice Name: __________________________________________________________________________________

Street Address: __________________________________________________________________________________

City: __________________________ County: ______________________

ZIP Code: __________________ Phone Number: __________________

Fax Number: __________________

E-mail Address: __________________________________________________________________________________

Type of Practice (circle one): Emergency Medicine      Family Practice      Infectious Disease
                             Internal Medicine      OB/GYN      Pediatrician
                             Student Health      Urgent Care
                             Other (specify): __________________________

*Fax completed forms to your local health department or to Nic Fisher, Ohio’s influenza surveillance coordinator at (614)-564-2499.

Revised 9/2013