

Completing Your Kentucky Immunization Registry Enrollment

Page 1 - Instruction Sheet

- KYIR Enrollment form-complete one per clinic/facility
- KYIR User Confidentiality Agreement-complete one per clinic/facility
- CHFS 219- complete one per log-in user

Page 2 - Provider details

Please complete all fields- if you do not understand any part of the form, please feel free to call or email the Kentucky Immunization Registry Help Desk.

Page 3 – User Accounts

“Login Users”

- **Signed CHFS 219’s must be received before access will be provided.**
Any and all staff members that may need access to Kentucky Immunization Registry (KYIR) must each read and complete a CHFS219 form to establish a User Account. Please feel free to make copies as needed.
 - ✓ Please note: **only the signature pages of the User Confidentiality Agreement needs to be submitted.** Please retain the “agreement page” for reference.
- **It is VERY important that each user provide an email address where they can be reached-** they will be placed in our User Distribution List and will receive messages regarding KYIR and the vaccine world. **Please provide work-issued email addresses if possible.** Please also make sure your computer network accepts our emails (sent from KYIRHelpdesk@ky.gov).

Adding Additional Users

- Please retain a blank CHFS219 form and the user accounts page of this form for use in adding additional users after being established as a KYIR provider. Please mail or fax completed user forms to the address/fax listed on the forms.

Signature of Provider Contact: Choose an individual to be the official “KYIR Contact” in your office and have them sign and date the bottom of Page 3. They will be the first point of contact in any future KYIR correspondence.

Submitting the application: Please mail or fax the completed application to the address/fax at the bottom of Page 3. Please allow 10 business days for processing.

Revised 1/2019



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. Please be sure your provider contact signs and dates page 3 before submitting. 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 (requires parental consent for Department of Education)

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: _____



User Accounts

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Please make copies as needed.

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Log In Users

Name	Title	E-mail Address	Associated Clinics*	Do they give immunizations?

**Associated Clinics are clinics that the individual works at beyond the clinic that has filled out this enrollment form.*

Signature of Provider Contact

Date Signed

Please complete this form and return to:

Kentucky Immunization Program-KYIR Helpdesk
275 East Main Street, HS2E-B Frankfort, KY 40621
Phone: 502-564-0038
Fax: 502-564-4760

For Office Use Only:

Date Received:

Received By:

Date KYIR Account Est:

Completed By:

