

**INFLUENZA**  
**SENTINEL PROVIDER SURVEILLANCE NETWORK ENROLLMENT FORM**

**Provider's First Name** \_\_\_\_\_

**Last Name** \_\_\_\_\_

**Degree (example: MD, PA, DO)** \_\_\_\_\_

**Practice Name (example: name of facility)** \_\_\_\_\_

**Contact Person** \_\_\_\_\_

**E-mail Address** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_

**State** \_\_\_\_\_

**Zip** \_\_\_\_\_

**Area Code / Phone Number** \_\_\_\_\_

**Alternate Phone** \_\_\_\_\_

**Fax Number** \_\_\_\_\_

**Type of Practice (example: pediatrician, family practice)** \_\_\_\_\_

**A certificate is sent annually to regular participants who submit 50 % or more reports.**

**Please indicate Provider or Clinic name for certificate** \_\_\_\_\_

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