

Meaningful Use Stage 2 Registration for Syndromic Surveillance

Health & Human Services Agency, Public Health Services, County of San Diego

Please complete this form and return to the Epidemiology & Immunization Services Branch (EISB) via fax (858-715-6458) or email (Jeffrey.Johnson@sdcountry.ca.gov). Upon receipt of the completed and signed form, EISB staff will contact you to discuss next steps and provide the appropriate Meaningful Use Stage 2 Specifications. For questions regarding Meaningful Use Stage 2 with the County of San Diego Public Health Services, please contact the Jeffrey Johnson at 619-692-8448.

Year of Meaningful Use Stage 2 Attestation (i.e. first, second, etc.): _____

Please complete:

Organization:	Date:	10 digit National Provider Identifier*:
Organization Object Identifier (OID):	M.U. Stage 1 San Diego County ID (if any):	Did your facility submit a Stage 1 M.U. test message to San Diego County? <input type="checkbox"/> Yes <input type="checkbox"/> No
Administrative/M.U. Contact Name:	Phone:	Email:
Information System Contact Name:	Phone:	Email:
Main Contact for M.U. Activities (if different):	Phone :	Email:
Type of Visits (i.e. prescheduled, emergency, etc):	Type of Patient Setting (i.e. outpatient, hospital, etc):	
Percent of Prescheduled Visits (up to 72 hrs prior):	Percent of Walk-in Visits for Acute Illness:	Number of Patient Visits Per Year (estimated):
Street Address of Organization (headquarters):	City, State: Zip	
Mailing Address (if different than street):	City, State: Zip	
Meaningful Use Attestation Planned Start Date:	Primary Attestation (Medicare or Medicaid):	Do you have the San Diego County HL7 2.5.1 Implementation Guide? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of Eligible Professionals (see CMS for definition):	Number of Physicians on staff:	Has your organization successfully tested a message through an HL7 message validator? <input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic Health Record (EHR) System Name & Vendor Name:	EHR Vendor Contact:	EHR Vendor Phone:
EHR Vendor Email:	Name of Integration Engine or Middleware Product/Vendor (if any):	
Comments/Questions:		

*10 digit National Provider Identifier (NPI) for the physical location of the hospital/clinic: <https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do>

Name and Title (Printed)

Signature & Date