

November, 2008

**West Virginia Department of Health and Human Resources  
Bureau for Public Health  
Influenza Sentinel Physician Enrollment Form**

Name of Physician or Practice: \_\_\_\_\_  
Degree of Provider (e.g., MD or DO) \_\_\_\_\_

Name of the Practice (if one): \_\_\_\_\_

Type of Practice: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(include city and zip code)

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

County: \_\_\_\_\_

Point of contact at physician office or facility: \_\_\_\_\_

Please indicate how the physician would like to receive current influenza information:  
(Check one)

- fax of weekly influenza report  
 email of weekly influenza report  
 View internet IDEP or CDC influenza website

Contact at local health department: \_\_\_\_\_

Date submitted this form: \_\_\_ / \_\_\_ / \_\_\_\_\_

Please fax this completed enrollment form to:

ATTN: Influenza Coordinator  
Infectious Disease Epidemiology Program  
Fax: 304-558-8736

Thank you.