

Influenza Sentinel Physician Enrollment Form

Name of Physician: _____
(Please include degree: MD, DO, PA, CNP etc.)

Name of Practice: _____

Point of contact at physician office: _____

Address: _____

City: _____ Zip: _____

Phone: (____) ____ - _____

Fax: (____) ____ - _____

E-mail: _____ (*required for communication during flu season)

County: _____

Is your office interested in receiving FREE influenza vaccine for your staff?
Yes No

How many doses of influenza vaccine would you need for your staff?

(Please order in increments of 10 with maximum request of 50)

Point of Contact at local health department:

Date submitted: ____ / ____ / ____

Please fax this completed enrollment form to:
ATTN: Influenza Coordinator
Infectious Disease Epidemiology Program
304-558-8736

Thank you!