

ImmuNet Enrollment Form

Maryland's Immunization Information System ([ImmuNet](#)) is a secure web-based registry operated by the Center for Immunization at the Maryland Department of Health (MDH). ImmuNet information is confidential, HIPAA and FERPA compliant, and available only to [authorized provider users](#) (per State Statute §18–109), and will not be released to third parties without written consent.

Note:

1. All ImmuNet authorized provider users are required to abide by the [ImmuNet Confidentiality and User Agreement](#) when you sign in to ImmuNet.
2. If your organization already has an ImmuNet Admin User(s), they can create an ImmuNet user account for you.
3. Organizations with more than one location must complete and submit an ImmuNet enrollment form for each location/address.

Enrollment Type:

Are you/your organization an authorized provider user?

☐ Yes ☐ No

Please refer to the authorized provider user list per [State Statute §18–109](#)

Does your organization administer vaccines (including seasonal vaccines like flu)?

☐ Yes ☐ No ☐ Unsure

If your organization does not administer vaccines, you do not need to set up a connection with ImmuNet. Contact [ImmuNet Support](#) if you need to report historical/missing records.

Select Type of Access

☐ Report administered vaccines to ImmuNet ☐ ImmuNet user account

If you need assistance with your existing account, contact [ImmuNet Support](#).

Organization Information

Organization Name

Organization Type:

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Childcare Facility | <input type="checkbox"/> Corrections/Detention Health Services | <input type="checkbox"/> Health Center | <input type="checkbox"/> Health Plan |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Hospital | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Medical Practice | <input type="checkbox"/> Public Health Provider | <input type="checkbox"/> School | <input type="checkbox"/> Urgent Care |
| <input type="checkbox"/> Other, specify type and reason to access ImmuNet: | | | |

If Medical Practice, indicate Specialty:

☐ Family ☐ Internal Medicine ☐ OB/GYN ☐ Pediatrics ☐ Other, please specify: _____

Organization Sub-Types (indicate where applicable):

Health Center: ☐ Community (non-FQHC/RHC) ☐ Migrant or Refugee ☐ Occupational ☐ STD/HIV Clinic
☐ Student

Long Term Care: ☐ *Nursing Home/Skilled Nursing Facility, Federally Qualified* ☐ *Nursing Home/Skilled Nursing Facility, Non-Federally Qualified* ☐ *Assisted Living* ☐ *Intellectual or Developmental Disability*
☐ *Combination (e.g., assisted living and nursing home in same facility)*

Pharmacy: ☐ *Chain* ☐ *Independent*

Public Health Provider: ☐ *Public Health Clinic* ☐ *FQHC* ☐ *RHC*

School Type: ☐ *Preschool* ☐ *Kindergarten* ☐ *Elementary* ☐ *Middle* ☐ *High*
☐ *Private* ☐ *Public*

Childcare Facility or Home Health Agency License Number (if applicable) _____

License Expiration Date _____

Organization Address _____ City _____ State _____ Zip Code _____ Phone Number (____) _____

Group/Individual NPI _____ VFC or Non VFC PIN (if applicable) _____

Report Administered Vaccines to ImmuNet

All providers who administer vaccines in Maryland are required to report to ImmuNet (per Maryland Statute [§18–109\(d\)\(6\)\(iii\)](#)).

Is your organization reporting to ImmuNet?

☐ Yes ☐ No ☐ Unsure

If you are not sure about your reporting status, learn more at health.maryland.gov/immunet to connect and report to ImmuNet.

Select your organization reporting method:

- ☐ EHR/EMR system (Preferred)
☐ Upload CSV file (No EHR/EMR or no immunization interface)
☐ Manual Data Entry (No electronic data system/Not Preferred)

Is your organization adopting or switching to a new EHR/EMR?

☐ Yes
☐ No

EHR/EMR Name: _____ EHR/IT Contact Email _____

If you indicated that your organization administers vaccines then you are required to report to ImmuNet. Complete and submit an [EHR On-Boarding Request Form](#) to connect your EHR/EMR to ImmuNet.

Requestor's Name _____

Requestor's Phone _____ Requestor's Email Address _____

User Account

User Name

Title/Department

Phone Number

Work Email Address

What do you need to do in ImmuNet? Select all applicable options:

- ☐ Look up Patient/Student immunization history
 - ☐ Manage Vaccine Inventory and Ordering
 - ☐ Run reports for my organization
 - ☐ Manage users in my organization (add/edit/delete user accounts)
(Please review the short tutorial videos on how to [add new users](#) and [edit existing users](#) in your organization.
Admin Users are also responsible for auditing their list of users on a regular basis.)
 - ☐ Report to ImmuNet (Upload CSV files)
 - ☐ Report to ImmuNet (Set up my EHR)
- EHR/IT Contact Name

 EHR/IT Contact Email

User Attestation

- ☐ I declare under penalty of perjury under the laws of the state of Maryland that this information is true and correct, and that I am an authorized provider user to access ImmuNet patient records and will abide by the ImmuNet user agreement.

Need to add more users? Contact your organization's Admin User to add them. If your organization does not have an Admin User, add information about additional users here:

Additional User:

Additional User Name

Additional User Title/Department

Additional User Phone Number

Additional User Work Email Address

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If you are requesting Admin User access (manage users), add your backup Admin User below:

Back Up Admin User Name

Back Up Admin User Title/Department

Back Up Admin User Phone Number

Back Up Admin User Work Email Address

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Date completed: _____

If you wish to keep a completed copy of your form, please make a copy before submitting the form.

Mail or Fax to

Maryland Department of Health
Center for Immunization - ImmuNet
201 West Preston Street 3rd Floor, Baltimore, MD 21201
Fax: (410) 333-5893

Once received, your request will be processed as quickly as possible. You should expect to receive your login credentials (if applicable) within 7-10 business days.

MDH (For Official Use Only):

Date Received: _____

Date Fulfilled: _____

Initials: _____