

**US OUTPATIENT INFLUENZA-LIKE ILLNESS SURVEILLANCE NETWORK (ILINet)
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. Please indicate to names which should be on your certificate, you may either elect to name individuals at the practice or an individual and the practice name.

- Certificate name 1: _____
- Certificate name 2: _____

For Questions or comments, please contact:

For more information on the US Outpatient Influenza-like Illness Surveillance Network (ILINet), please contact: [Owen Simwale](#), ILINet Coordinator; or Dr. [Kumar Nalluswami](#) or [download enrollment form](#) to participate

Last Updated: Thursday, February 11, 2010