HL7 Clinic Contact Info Sheet

Clinic Name: ________________________________  VFC #: _______________

Clinic Location: ____________________________________________

Primary Contact: _______________________________ __________________________________

First       Last

Direct Phone Number: (__ __ __) - __ __ __ - __ __ __ __ ext: ____________

Email Address: _____________________________________________________________

Please assign and train a secondary responsible person.

Secondary Contact: _________________________ _____________________________

First      Last

Direct Phone Number: (__ __ __) - __ __ __ - __ __ __ __ ext: ____________

Email Address: _____________________________________________________________

I understand that as an HL7 Clinic Contact, I am expected to

• Address data quality issues within 2 days of notification by SAIRS Team.
• Notify SAIRS Team if a SAIRS user is no longer employed at your clinic within 2 days of their last work day.
• Check the inbox of the email address provided on this form at least weekly.

If data quality is a continued unresolved issue, SAIRS reserves the right to disconnect data exchange. Once issue has been resolved, connection will be reestablished.

_____________________________________   ___________________
Signature of Primary Contact    Date

_____________________________________  ___________________
Signature of Secondary Contact    Date