Intent to Register

Organization or Eligible Hospital (EH) Name:

Address:

City, State, Zip:

Phone:

Primary Contact Name:

Contact Email:

Reporting Period is (mm/dd/yyyy – mm/dd/yyyy):

If attesting in a Participating Program:

I/Organization are registering intent to report on the following Meaningful Use Measure(s):

☐Immunization Information System

☐Reportable Lab Results

☐Electronic Syndromic Surveillance Data

☐Electronic Case Reporting

Please complete this form and email to: hss.hitinfo@alaska.gov