TEXAS
Department of
State Health Services

*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 who submit 50 % or more reports.*

*Please indicate Provider or Clinic name for certificate* ______________________________

☐ *Unable to participate at this time*

*Irene Brown*
*Infectious Disease Control Unit*
*Phone: (512) 458-7111, ext. 6878*
*Fax: (512) 458-7616*
*E-mail: irene.brown@dshs.state.tx.us*