ADPH Influenza-like Illness Reporting Network Application

☐ I agree to become a U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) participant. Providers are asked to report the number of patients with ILI by Age Group and the total number of patients seen for the week.

Signature ____

Thank you!! Please complete the information below and fax to (334) 206-3734.

Practice Name: ____

Practice Type: ☐ Emergency Medicine ☐ Family Practice ☐ Infectious Disease
☐ Internal Medicine ☐ OB/GYN ☐ Pediatrician
☐ Student Health ☐ Urgent Care ☐ Other

Primary Contact's Name: ______________________________________

Primary Contact's Phone: ______________________________________

Practice Mailing Address: ______________________________________

City ______________________ Zip __________

Practice Physical Address: ______________________________________

City ______________________ Zip __________

County where practice is located: ______________________________

Practice Phone #: ( ) ______________________________

Practice Fax #: ( ) ______________________________

E-mail address (to receive program updates): ______________________________