



# Arkansas WebIZ Facility Enrollment

## Facility Information

**Facility Name:**

**Practice Type:**

**Street Address:**

**County:**

**City:**

**State:**

**Zip Code:**

**Facility Phone Number:**

**Facility Fax Number:**

**Primary Contact Person:**

**Contact Phone Number:**

**Contact Email Address:**

**Facility Hours:**

**Monday:**

**Closed for lunch:**

**Tuesday:**

**Closed for lunch:**

**Wednesday:**

**Closed for lunch:**

**Thursday:**

**Closed for lunch:**

**Friday:**

**Closed for lunch:**

## WebIZ Agreement

To participate in the Arkansas Immunization Information System, named Arkansas WebIZ, I agree to the following conditions, on behalf of myself and all practitioners associated with this medical office, group practice, health maintenance organization, health department, community/migrant/rural health clinic, or other entity of which I am the physician-in-charge or equivalent:

1. As the physician-in-charge, I hereby agree to ensure this medical office, group practice, health maintenance organization, health department, community/migrant/rural health clinic, or other entity of which I am the physician-in-charge (hereby referred to as facility), in addition to all employees to which access to Arkansas WebIZ will be granted, will comply with all rules and regulations governing the Arkansas Immunization Information System (Arkansas WebIZ) according to Act 432 of 1995 and Act 869 of 1997 as amended.
  
2. In the same manner, I agree to ensure this facility and all users of the Arkansas WebIZ system from this facility remain compliant to and strictly adhere to the protocols, security measures, and training required by the Arkansas Department of Health, including, but not limited to, the following:
  - I will ensure that all users of the Arkansas WebIZ system within this facility never share the details of their usernames and/or passwords with any other individual. I will further ensure that every individual that needs access to the Arkansas WebIZ system will follow the procedures for setting up an individual user account.
  - This facility will never allow the use of any generic user account designed to give multiple individuals access to the Arkansas WebIZ system under an unidentifiable username (i.e., school user, nurse1, front desk, etc.)
  - I understand that by accessing the Arkansas WebIZ system my activity and the activity of all users of this facility are tracked, stored, and permanently affixed with the name of the user that performed that action and not capable of being altered or destroyed. This includes modules accessed, patients researched, records updated, and all other actions performed within the Arkansas WebIZ system.
  - I will ensure that all Arkansas WebIZ system users in this facility understand that Arkansas State Law dictates that an immunization record is determined to be part of a patient's official medical record, and that changing/altering an immunization record in any means without sufficient supporting evidence, recording false information on an immunization record, or participating in any other activity that detracts from the ability to identify the patient of record, is against state and federal laws.
  
3. I attest that all Arkansas WebIZ users from this facility have been fully trained in, and understand, the Health Insurance Portability and Accountability Act (HIPAA) (42 USC 1320d-6) as it pertains to the use of an electronic health records database as well as immunizations data.
  
4. I understand that any wrongful disclosure of individually identifiable health information retrieved from the Arkansas WebIZ system, by any user from this facility, will be considered a violation of the Health Insurance Portability and Accountability Act (HIPAA) (42 USC 1320d-6).
  
5. I further understand that the level of violation and associated penalty is determined by the Health Information Technology for Economic and Clinical Health Act (HITECH).

6. If, at any time, the contact information for this facility (including telephone number, fax number, and e-mail address) change, I will notify the Arkansas WebIZ Program immediately to report this change.
7. I will ensure that this facility will immediately contact the Arkansas WebIZ Program when an employee with access to Arkansas WebIZ leaves this facility to have that user deleted from this facility account in WebIZ. I understand that failure to notify the Arkansas WebIZ Program to report this change will result in this facility being responsible and liable for all actions performed by that user, up until the moment that the user received said notice.
8. I understand that being granted access to Arkansas WebIZ does not commit the Arkansas Department of Health to any expense.
9. I understand that non-compliance with any section of this enrollment form will result in an immediate loss of access to Arkansas WebIZ for both the offending individual and the facility.

**I certify that I have read, reviewed, and thoroughly understand the terms and conditions as outlined and explained in this Arkansas WebIZ access user agreement. I understand that any deviation from this agreement will result in suspension of my user account and, depending on the severity of the offense, the suspension of the organization that I represent. I understand that suspension of my organization's WebIZ account could have a direct impact on the organization's ability to complete and/or attest for meaningful use and/or other initiatives. I understand that checking the box below and typing my name holds the same legal weight as my hand-written signature.**

I Accept and Affix My Signature

Signature:

(Enter your name as you would sign it)

Date of Signature:

**To enroll your facility in WebIZ, submit a ticket to the WebIZ help desk at <https://adhimmiregistry.hesk.com/index.php?a=add&catid=93> and attach this completed form to your ticket.**