

895 North Capitol Street, NE, 6th Floor, Washington, DC 20002

DC-HIE DIRECT Messaging Enrollment Form for Providers

Part 1: PRIMARY END USER AND AUTHENTICATION INFORMATION

District of Columbia Department of Health

Certificate or Registration Number _____

License, Certificate or Registration Type _____

NPI Number _____

How many health care providers will be served by this DIRECT Messaging address? _____

Last Name _____ First Name _____

Organization Name _____

Organization Address Line 1 _____ Line 2 _____

City _____ State _____ Zip Code _____

Office Phone Number _____

Email Address _____

Mobile Phone Number (must be SMS enabled) _____

Mobile Phone Carrier _____

Messaging Notification Preference:

Do you want a notification alert when new messages arrive in your DIRECT Messaging Inbox?

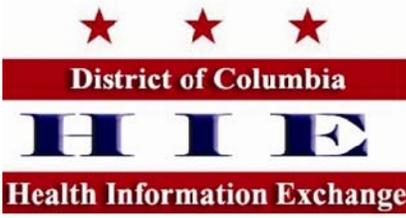
Yes No

I want my notifications and my one time password sent to my:

Email address

Mobile Phone

Both my Email and my phone



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Part 2: DELEGATE END USER AND AUTHENTICATION INFORMATION

Delegate End User 1:

Last Name _____ First Name _____

Email Address _____

Mobile Phone Number (must be SMS enabled) _____

Mobile Phone Carrier _____

Messaging Notification Preference:

Do you want a notification alert when new messages arrive in the Primary User's DIRECT Messaging Inbox

Yes No

I want message notifications and my one time password sent to my:

- Email address
- Mobile Phone
- Email and my phone

Delegate End User 2:

Last Name _____ First Name _____

Business Email Address _____

Mobile Phone Number (must be SMS enabled) _____

Mobile Phone Carrier _____

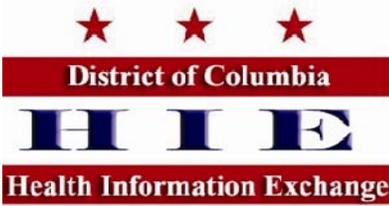
Messaging Notification Preference:

Do you want a notification alert when new messages arrive in the Primary User's DIRECT Messaging Inbox

Yes No

I want message notifications and my one time password sent to my:

- Email address
- Mobile Phone
- Both my Email and my phone



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The undersigned has presented current government-issued ID containing the individual's name and photograph.

The undersigned applicant warrants, represents, and attests that all facts and information provided are accurate, current, complete and not misleading and that he or she:

1. Has completely and accurately represented his or her identity;
2. Is a health care provider with a valid license, certificate or registration issued by the District of Columbia Department of Health to practice his or her clinical occupation and that such license, certificate or registration is currently in effect and in good standing.

The applicant agrees to accurately represent him or herself in all communications using DC-HIE DIRECT Messaging.

THIS DOCUMENT MUST BE SIGNED IN THE PRESENCE OF THE NOTARY.

Signature: _____ Date: _____

Part 3 – INSTRUCTIONS FOR NOTARY

FOR THE PURPOSES OF THIS DOCUMENT, PERSONAL ACQUAINTANCE WITH THE INDIVIDUAL IS INSUFFICIENT. YOU MUST:

1. Review a current government-issued ID containing the individual's name and photograph.
2. Ensure that the name on the government-issued ID matches the name provided by the applicant in Part 1 and the applicant's signature.

Part 4 – TO BE COMPLETED BY THE NOTARY

CITY/COUNTY OF _____, to-wit:

The foregoing instrument was acknowledged before me in the above-stated jurisdiction this ____ day of _____, ____ by _____ who personally appeared before me and signed or attested the same in my presence, and presented a government-issued photo ID card as proof of his/her identity.

Notary Public

Notary registration number: _____ My commission expires: _____

This space reserved for notary seal: