Oregon Health Authority
OFFICE OF HEALTH INFORMATION TECHNOLOGY

Flat File Directory Exchange Enrollment Form

Organization Information

Name of Organization	
Street Address	
City ST ZIP Code	
Work Phone	
Email Address	
EHR System in place	
EHR System Version	
Health Information Service Provider (HISP) chosen	
Attestation Stage for MU	
Anticipated Use	

Point of Contact Information

Point of Contact Name	
Department/Position Title	
Street Address	
City ST ZIP Code	
Work Phone	
Mobile Phone (optional)	
Email Address	
Direct email address	
Secondary Point of Contact	
Email Address	

Internal Use Only:

Date Received _____

☐ Verify that Enrollment Form is complete in full

☐ Verified HISP

Internal signature _____