This article highlights influenza immunization and current requirements for reporting influenza and influenza-like illness (ILI).

**Vaccination**

This year’s seasonal influenza vaccine virus strains are identical to those contained in the 2010–11 vaccine: A/California/7/2009 (H1N1)-like, A/Perth/16/2009 (H3N2)-like, and B/ Brisbane/60/2008-like antigens. The influenza A (H1N1) vaccine virus strain is derived from a 2009 pandemic influenza A (H1N1) virus. Available vaccines include injectable killed preparations of differing formulations for specific age groups (e.g., pediatric, adult, and high-dose geriatric) and live attenuated influenza vaccine (LAIV) formulated for nasal inhalation by immunocompetent, non-pregnant individuals 24 months to 49 years of age. A table of vaccine formulations and dosing is attached to the Bulletin (see page 6).

All persons aged 6 months and older should be vaccinated annually. Protection of persons at higher risk for influenza-related complications should continue to be a focus of vaccination efforts if supplies are limited or while practices are transitioning to routine vaccination of all persons aged 6 months and older. A summary of priority groups for vaccination can be viewed at [http://www.cdc.gov/flu/professionals/acip/flu-vax.htm](http://www.cdc.gov/flu/professionals/acip/flu-vax.htm).

YHD anticipates no shortage or delay in vaccine supplies this season.

**Reporting**

The following conditions are reportable to YHD by health care providers and facilities:

- **Laboratory-confirmed influenza-associated death.** This would include any death resulting directly or indirectly from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory test. There should be no period of complete recovery between the illness and death.
- **Novel influenza virus.** This would include any suspected or confirmed influenza infections, including avian influenza A (H5N1), unexplained critical illness or death with suspicion of influenza-like illness. This would include any unexplained critical illness and/or death in individuals under 50 years of age.
- **Outbreaks of suspected or confirmed ILI in long term care facilities.**

YHD Communicable Diseases staff is available to facilitate testing, investigation, and reporting of patients, decedents, and facilities meeting these criteria. Please call (509) 249-6541 for further assistance.

**Laboratory Surveillance**


**Sentinel Provider Surveillance**

YHD continues to recruit volunteers for weekly reporting of the total number of patients seen and number of patients with ILI seen by age group. YHD also facilitates arrangements for submission of specimens from ILI patients to WSPHL for influenza testing. Beyond the subsidized testing for select patients and the good of contributing to the regional ILI surveillance network, no compensation or benefit accrue to participating providers. Your participation is needed. An information sheet and provider enrollment form can be found on pages 8 & 9 of this Bulletin. For more information on becoming a sentinel ILI provider, please call Marianne Patnode at (509) 249-6509.

**Resources**

Comprehensive information regarding the...
Epidemiology and Control of Gonorrhea in Yakima County

Introduction

Through August 31, 2011 the 60 case reports of Neisseria gonorrhea (gonorrhea) submitted in Yakima County represent a 300% increase compared to the 15 cases reported during the same period in 2010. Despite the increase, the 2011 figure corresponds to an annualized incidence (38 cases per 100,000) that is comparable to the statewide rate (41 per 100,000). Overall, trends in gonorrhea for Yakima County and Washington State have roughly paralleled one another across the past two decades, with Yakima County showing more variability over time due to its smaller size (Figure below). Potential explanations for the rising trend may include increased transmission, better case detection, more complete case reporting, or a combination of these factors. This article reviews key features of the demographics of reported cases, highlights diagnosis and treatment recommendations, and reviews the importance of clinicians working with patients to get their partners treated.

Demographics

This year’s cases, in aggregate, have the following unusual features that set them apart from typical gonorrhea epidemiology: women slightly outnumber men; men who report having sex with other men represent only a small minority of cases; and white non-Hispanics outnumber other race-ethnicity groups (especially among women). The recent cases do remain typical of gonorrhea epidemiology in the following respects: the peak age-specific incidence for women is in the 15-29 year age group and for men is in the 15-29 year age group. Family planning clinics and hospital emergency departments, sites serving patients with limited access to primary care and at higher risk for sexually transmitted infections, submit over two-thirds of case reports.

Diagnosis

Diagnostic testing should be directed at men presenting with urethritis or epididymitis, women presenting with cervicitis or endometritis/salpingitis, or patients of either gender presenting with proctitis. Screening efforts should be extended toward men and women under 25-30 years of age who have had multiple sexual partners in the preceding several months, as well as all MSM. Testing modalities include nucleic acid amplification (NAA) and culture. Specimens should be collected from all exposed sites, including the pharynx, especially for MSM. NAA performs best on urine, cervical and urethral specimens, while culture shows good performance from cervical, urethral, rectal and pharyngeal sites.

Treatment

Providing appropriate treatment for gonorrhea is important for ensuring clinical and microbiologic cure and for limiting further emergence of antimicrobial resistance. In accordance with the Centers for Disease Control and Prevention’s (CDC’s) STD Treatment Guidelines, YHD recommends the following therapy for uncomplicated gonococcal infections: ceftriaxone 250 mg intramuscularly in a single dose plus either azithromycin 1g orally in a single dose or doxycycline 100 mg orally twice a day for 7 days. If ceftriaxone is not available, acceptable alternatives include either cefixime (400 mg orally in a single dose) or a single-dose injectable cephalosporin (again, plus either azithromycin or doxycycline). For patients with allergy or other contraindications to use of these agents, consult an infectious diseases specialist or call YHD at (509) 249-6531.

YHD emphasizes that DUAL treatment with BOTH a cephalosporin (ideally intramuscular ceftriaxone) PLUS either azithromycin or doxycycline is the standard of care for treatment of gonococcal infections. When a patient has no absolute contraindications to the recommended regimen

Gonorrhea Incidence, Yakima County & Washington State, 1992-2011

![Gonorrhea Incidence Graph]
above, alternative therapies are strongly discouraged given concerns of rising resistance and the possibility of treatment failures.

**Expedited Partner Therapy**

Expedited partner therapy (EPT) remains a key disease control intervention to interrupt transmission and reduce re-infection of previously treated cases. EPT provides opportunities for the treatment of sex partner(s) to gonorrhea and chlamydia cases. It eliminates the barrier of requiring pre-treatment clinical testing and evaluation of those partners. Clinical trials have shown good safety and superior performance compared to traditional partner notification services. While 99% of case reports submitted by diagnosing clinicians for gonorrhea and chlamydia in 2011 have included a plan for partner management, the ratio of verifiably treated partners to reported case has been only 0.28:1 (199:722) in 2011.  

Candidates for EPT include any sex partners from the presumed infectious period, which begins 60 days prior to diagnosis and extends through the date of treatment. The logistics of EPT involve calling in or writing a prescription for a chlamydia or gonorrhea “partner pack” for each partner. A list of participating pharmacies that provide the fully subsidized treatment packs is located at [http://www.doh.wa.gov/cfh/STD/EPT/counties.htm](http://www.doh.wa.gov/cfh/STD/EPT/counties.htm).

Clinicians should request assistance for sex partner follow-up from YHD on the case report if (a) the patient is unable or unwilling to contact one or more partners, or b) the patient has had 2 or more sex partners in the last 60 days, or c) the patient is an MSM or d) the diagnosis is syphilis. In many settings, EPT coverage and efficiency may be increased by delegating the logistics to a non-clinical team member. For technical consultation in carrying out EPT, please contact YHD at (509) 249-6531. Additional background information on EPT can be viewed at DOH’s EPT website and prior editions of this Bulletin.  

**Conclusion**

In summary, YHD can identify no clear explanation for the rise in reported cases of gonorrhea in Yakima County in 2011. These cases have been characterized by unusual epidemiologic features in some respects (i.e., preponderance of white, non-Hispanic women and low representation of men reporting same-sex sexual activity). Clinicians should be aware of the changing demographics of recently reported cases and may want to consider expanding their testing practices in line with these findings, as well as making reasonable efforts to ask about same-gender sexual activity and to include that in the case report. Treatment should include dual therapy (ceftriaxone-or-cefixime plus azithromycin-or-doxycycline). Expedited partner therapy provides an efficient and affordable means for clinicians to ensure treatment of sex partners, but its potential effectiveness still has not been realized in Yakima County.

**References**


---

**Children’s Oral Health Survey Shows Mixed Results—YHD Oral Health Program Eliminated Due to State Budget Cuts**

**Report Summary**

The results of the Washington State Department of Health’s *Smile Survey 2010* were released earlier this year. Compared to 2005, the overall results for 2010 were somewhat reassuring. Statewide in 2010, preschoolers in Head Start and the Early Childhood Education Assistance Program had lower rates of untreated decay and need for dental treatment than in 2005, and third graders also had lower rates of untreated decay (Table 1). Although overall sealant coverage (~50%) did not increase across the five-year interval, sealant coverage did increase from 45 to 56% among racial and ethnic minorities. When compared to the Healthy People 2020 objectives, Washington State met the objectives related to untreated decay and sealant rates for both preschoolers and third graders (data not presented).

**Table 1. Summary of Statewide Smile Survey Results, 2005-2010**

<table>
<thead>
<tr>
<th></th>
<th>Head Start/ECEAP Preschoolers (n=1,597)</th>
<th>Public School Kindergartners (n=2,858)</th>
<th>Public School Third Graders (n=2,875)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS 2005 (%)</td>
<td>SS 2010 (%)</td>
<td>SS 2010 (%)</td>
<td>SS 2005 (%)</td>
</tr>
<tr>
<td>Decay experience</td>
<td>46</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>Untreated decay</td>
<td>26</td>
<td>13*</td>
<td>19</td>
</tr>
<tr>
<td>Rampant decay</td>
<td>16</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>Need for dental care</td>
<td>Not applicable</td>
<td>5</td>
<td>17</td>
</tr>
</tbody>
</table>

*Statistically significant different from Smile Survey 2005 result at 0.05 level.

**Source:** Washington State Department of Health (2011)

On the other hand, sealant coverage fell from 53 to 48% for non-minority children. Children who received subsidized lunches in 2010 were about 50% more likely to have decay or rampant decay than children not so subsidized. According to the report, this was particularly true for Hispanic children and those who speak another language at home (especially Spanish), but data further specifying that finding was not provided in the report. Furthermore, the overall prevalence of tooth decay among preschoolers and third graders statewide fails to meet Healthy People 2010 objectives (40% vs. 30% and 58% vs. 49%, respectively).

Preliminary analysis of local results for caries history,
untreated decay, rampant decay, and Healthy People 2020 objective achievement among Yakima County participants appears qualitatively similar to the statewide figures set forth below (Figures 1 and 2).

Figures 1.

Water Fluoridation Data

In addition to dental hygiene, good dietary habits, and preventive and restorative dental care, water fluoridation remains a key community-based tool for promoting oral health. In Yakima County, approximately 90% of residents live in areas served by water systems that meet or exceed 0.8mg/L fluoride, either through addition or natural sources. Of the remainder, about 9,000 residents in Grandview, 15,000 Sunnyside, and 5,000 in Wapato are served by systems providing ~0.7mg/L. This leaves only a few hundred residents drinking residential water that falls substantially below the minimum recommended fluoride level for dental benefits.

Discussion

Beyond the impact on acute oral health (e.g., pain, infection), prevention and treatment of dental caries has lasting benefits toward child development and adult well-being. In the early years, these include nutrition, sleep, socialization, attention, speech, school attendance, and health care spending. In the middle and later years of life, dental health also affects nutrition, health care spending, work attendance, earnings, morale, stress, and overall life satisfaction. Oral health status and access to care are closely linked to socioeconomic status, particularly in the lowest quintile of income. While the individual impacts may be small on a per capita basis, the cumulative impact on overall health and welfare of the population can be substantial given that one in five children have rampant tooth decay by the third grade (see Table 1).

Efforts to prevent tooth decay and promote oral health during early childhood and throughout the lifespan are worthwhile on their own merits, as well as for their branching health and socioeconomic impacts. Furthermore, the findings in this report and the supporting body of academic research suggest that monitoring oral health may be a sensitive indicator of our overall effectiveness in protecting and promoting general health and well-being throughout the lifespan.

Consequently, it came as a great but unavoidable disappointment that the recent budget reductions at the state level resulted in YHD having to terminate its state-funded Oral Health Program. YHD has discontinued education and outreach services related to oral health in 2011. YHD would like to thank Heather Young for her dedication and expertise in leading the program for so many years. A full copy of the Smile Survey 2010 and the most recent list of 25 Yakima County providers of dental services for low-income and Medicaid-funded patients can be accessed on the YHD website at http://yakimahealthdistrict.org/w/home/community-health/childrens-health/oral-health/.

Detailed knowledge of Yakima County’s specific results from the Smile Survey is a critical local assessment and planning need, regardless of whether or not YHD itself has an oral health program. This is particularly true given that the statewide report highlighted low income, ethnic minority status, and Spanish-spoken-at-home as risk factors for decay and lack of access to care. YHD has submitted a request for the full data set and will update this report with more detailed local analyses in a subsequent edition of the Bulletin. YHD will also continue to disseminate state and national information of relevance to local oral health such as this and will make reasonable attempts to foment and support community-based action to promote oral health.

For more information, please contact Sheryl DiPietro at (509) 249-6517.

References


## Notifiable Conditions Summary
### Jan - Aug, 2011

<table>
<thead>
<tr>
<th>Notifiable Condition (includes confirmed and probable cases)</th>
<th>Cases</th>
<th>Total Cases by Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campylobacteriosis</td>
<td>89</td>
<td>88</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>814</td>
<td>738</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Genital Herpes - Initial</td>
<td>51</td>
<td>41</td>
</tr>
<tr>
<td>Giardiasis</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>60</td>
<td>15</td>
</tr>
<tr>
<td>Hepatitis A acute</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hepatitis B acute</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hepatitis B chronic</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Hepatitis C acute</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis C chronic</td>
<td>129</td>
<td>175</td>
</tr>
<tr>
<td>HIV/AIDS Cumulative Living</td>
<td>181</td>
<td>175</td>
</tr>
<tr>
<td>HIV/AIDS Deaths</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>HIV/AIDS New</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Pertussis</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Salmonellosis</td>
<td>15</td>
<td>36</td>
</tr>
<tr>
<td>Shigellosis</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>STEC (enterohemorrhagic E. coli)</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Syphilis - Primary and Secondary</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>
### TABLE. Influenza vaccine information, by age group — United States, 2011–12 influenza season

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Trade name</th>
<th>Manufacturer</th>
<th>Presentation</th>
<th>Mercury content (µg Hg/0.5 mL dose)</th>
<th>Ovalbumin content (µg/0.5 mL dose)</th>
<th>Age group</th>
<th>No. of doses</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIV</td>
<td>Fluzone</td>
<td>Sanofi Pasteur</td>
<td>0.25 mL prefilled syringe</td>
<td>0.0</td>
<td>⎯†</td>
<td>6–35 mos</td>
<td>1 or 2§</td>
<td>IM†</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.5 mL prefilled syringe</td>
<td>0.0</td>
<td>⎯†</td>
<td>≥36 mos</td>
<td>1 or 2§</td>
<td>IM†</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.5 mL vial</td>
<td>0.0</td>
<td>⎯†</td>
<td>≥36 mos</td>
<td>1 or 2§</td>
<td>IM†</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.0 mL multidose vial</td>
<td>25.0</td>
<td>⎯†</td>
<td>≥6 mos</td>
<td>1 or 2§</td>
<td>IM†</td>
</tr>
<tr>
<td>TIV</td>
<td>Flurin</td>
<td>Novartis Vaccines</td>
<td>0.5 mL prefilled syringe</td>
<td>≤1</td>
<td>≤1</td>
<td>≥4 yrs</td>
<td>1 or 2§</td>
<td>IM†</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.0 mL multidose vial</td>
<td>25.0</td>
<td>≤1</td>
<td></td>
<td></td>
<td>IM†</td>
</tr>
<tr>
<td>TIV</td>
<td>Fluarix</td>
<td>GlaxoSmithKline</td>
<td>0.5 mL prefilled syringe</td>
<td>0</td>
<td>≤0.05</td>
<td>≥3 yrs</td>
<td>1 or 2§</td>
<td>IM†</td>
</tr>
<tr>
<td>TIV</td>
<td>FluLaval</td>
<td>ID Biomedical Corporation of Quebec (distributed by GlaxoSmithKline)</td>
<td>5.0 mL multidose vial</td>
<td>25.0</td>
<td>≤1</td>
<td>≥18 yrs</td>
<td>1</td>
<td>IM†</td>
</tr>
<tr>
<td>TIV</td>
<td>Affuria</td>
<td>CSL Biotherapies (distributed by Merck)</td>
<td>0.5 mL prefilled syringe</td>
<td>0.0</td>
<td>≤1</td>
<td>≥29 yrs**</td>
<td>1</td>
<td>IM†</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.0 mL multidose vial</td>
<td>24.5</td>
<td>≤1</td>
<td></td>
<td></td>
<td>IM†</td>
</tr>
<tr>
<td>TIV</td>
<td>High-Dose</td>
<td>Sanofi Pasteur</td>
<td>0.5 mL prefilled syringe</td>
<td>0.0</td>
<td>⎯†</td>
<td>≥65 yrs</td>
<td>1</td>
<td>IM†</td>
</tr>
<tr>
<td>TIV</td>
<td>Intradermal</td>
<td>Sanofi Pasteur</td>
<td>0.1 mL prefilled microinjector system</td>
<td>0.0</td>
<td>⎯†</td>
<td>18–64 yrs</td>
<td>1</td>
<td>ID</td>
</tr>
<tr>
<td>LAIV</td>
<td>FluMist§§</td>
<td>MedImmune</td>
<td>0.2 mL prefilled intranasal sprayer</td>
<td>0.0</td>
<td>⎯‖</td>
<td>2–49 yrs***</td>
<td>1 or 2§</td>
<td>IN</td>
</tr>
</tbody>
</table>

**Abbreviations**: TIV = trivalent inactivated vaccine; LAIV = live attenuated influenza vaccine; IM = intramuscular; ID = intradermal; IN = intranasal.

* Vaccination providers should check Food and Drug Administration–approved prescribing information for 2011–12 Influenza vaccines for the most updated information.

† Information not included in package insert but is available upon request from the manufacturer, Sanofi Pasteur, by telephone, 1-800-822-2463, or e-mail, MIS.Email@sanofipasteur.com.

§ Children aged 6 months through 8 years who did not receive seasonal influenza vaccine during the 2010–11 influenza season should receive 2 doses at least 4 weeks apart for the 2011–12 season. Those children aged 6 months through 8 years who received 2 doses of the 2010–11 seasonal vaccine require 1 dose for the 2011–12 season.

†† For adults and older children, the recommended site of vaccination is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh.

** Age indication per package insert is ≥5 years; however, the Advisory Committee on Immunization Practices recommends Affuria not be used in children aged 6 months through 8 years because of increased reports of febrile reactions in this age group. If no other age-appropriate, licensed inactivated seasonal influenza vaccine is available for a child aged 5–8 years who has a medical condition that increases the child’s risk for influenza complications, Affuria can be used; however, providers should discuss with the parents or caregivers the benefits and risks of influenza vaccination with Affuria before administering this vaccine. Affuria may be used in persons aged 29 years.

††† Intradermal: A 0.5-mL dose contains 60 μg each of A/California/7/2009 (H1N1)-like, A/Perth/16/2009 (H3N2)-like, and B/Brisbane/60/2008-like antigens.

§§ FluMist is shipped refrigerated and stored in the refrigerator at 35°–46°F (2°–8°C) after arrival in the vaccination clinic. The dose is 0.2 mL divided equally between each nostril. Health-care providers should consult the medical record, when available, to identify children aged 2–4 years with asthma or recurrent wheezing that might indicate asthma. In addition, to identify children who might be at greater risk for asthma and possibly at increased risk for wheezing after receiving LAIV, parents or caregivers of children aged 2–4 years should be asked: “In the past 12 months, has a health-care provider ever told you that your child had wheezing or asthma?” Children whose parents or caregivers answer “yes” to this question and children who have asthma or who had a wheezing episode noted in the medical record within the past 12 months should not receive FluMist.

‖‖ Insufficient data available for use of LAIV in egg-allergic persons.

*** FluMist is indicated for healthy, nonpregnant persons aged 2–49 years.
This class is for those who are responsible for administering TB skin tests. You will learn the basics of tuberculosis infection and disease. We will discuss who needs skin testing and why, as well as how to administer, read, and interpret a TB skin test. We will discuss the limitations of the current TB tests and cover recommended follow up after a positive test. This class will include hands on practice of TB skin tests, so be prepared to administer and receive saline injections. Class size will be limited. Please send me a fax/e-mail with completed registration form by October 21st. Fax: (509) 249-6632 Email: David.Miller@co.yakima.wa.us. There is no fee for this class.

Want to have a class at your facility? If your facility is in Yakima County and you have at least 8 people who can commit to participating, then we can come to you. Call/E-mail David Miller for details.
TB Skin Testing Class Registration

Name:

Degree or license (RN, MSN, MD):

E-Mail:

Phone:

Address:

Job Title:

Company:

You will sign in at the beginning of class. Those who sign in and complete the entire class will have a certificate e-mailed to them after the class.

Please complete this form and fax/e-mail back to me at (509)249-6632. If you have any questions call David Miller at (509)249-6532.
Now You Can Help With...

Influenza Surveillance for the 2011–12 Season

...in Only a Few Minutes a Week!

What is an influenza ILINet provider?

An influenza ILINet provider conducts surveillance for influenza-like illness (ILI) in collaboration with the Washington State Department of Health and the Centers for Disease Control and Prevention. Data reported by ILINet providers, in combination with other influenza surveillance data, provide a national picture of influenza virus and ILI activity in the U.S. Approximately 3,400 providers were enrolled in ILINet during the 2010–11 influenza season.

What data do ILINet providers collect? How and to whom are data reported?

ILI providers report each week the total number of patients seen for any reason and the number of patient visits for influenza-like illness (ILI) by age group (0–4 years, 5–24 years, 25–49 years, 50–64 years, ≥65 years).

Influenza-like Illness (ILI) Case Definition

Fever (≥ 100°F [37.8°C]), oral or equivalent
- AND -
cough and/or sore throat
(in the absence of a known cause other than influenza)

These data are transmitted once a week via the Internet or fax to a central data repository at CDC. In addition, sentinel providers can submit specimens from patients for influenza testing free of charge.

Who can be an ILINet Provider?

Providers of any specialty in any type of practice are eligible to be ILINet providers:

- Emergency Medicine
- Family Practice
- Infectious Disease
- Internal Medicine
- OB/GYN
- Pediatrics
- Student Health
- Urgent Care

Practice settings that are not eligible are elementary, middle, or high school health centers, and any type of institutional setting such as nursing homes or prisons.

Why Volunteer?

Influenza viruses are constantly evolving and cause substantial morbidity and mortality every year. ILINet data are important in monitoring influenza activity on the local, state, and national level. Also, ILINet data, in combination with other influenza surveillance data, can be used to guide prevention and control activities, vaccine strain selection, and patient care. The most important consideration is that the data provided assist with protecting the public’s health.

For more information on Influenza Sentinel Provider Surveillance, please contact Kathy Lofy at (206) 418-5510 (kathy.lofy@doh.wa.gov)
Sentinel Provider Enrollment Form 2011-2012

If you would like to participate in ILI Net during the 2011-2012 season, please check the below information and return this form to Kathy Lofy via e-mail (kathy.lofy@doh.wa.gov), fax (206-418-5515), or mail (1610 NE 150th St, Shoreline, WA, 98155). Please call or e-mail Kathy Lofy (206-418-5510) with any questions.

All Participating Provider Names and Degrees (e.g., MD, ARNP, DO, PA-C):

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Primary contact person:

Backup contact person:

Clinic or practice name:

Area of practice (please mark one):

- Emergency Medicine
- Family Practice
- Infectious Disease
- Internal Medicine
- OB/GYN
- Pediatrics
- Student Health
- Urgent Care
- Other

Mailing address:

County:

Contact phone number:

Fax number:

E-mail address(es) of participating providers and contacts*:

Please indicate whether you would like to participate in seasonal or year-round surveillance: Seasonal year-round surveillance seasonal surveillance (October 2, 2011 – May 19, 2012)

Please indicate the type of surveillance you are willing to participate in:

- Submit specimens for influenza testing only
- Report ILI counts weekly only
- Report ILI counts weekly and submit specimens for influenza testing

*E-mail will be used to distribute weekly influenza surveillance updates as well as to communicate important messages and updates regarding participation in the Influenza Sentinel Provider Surveillance Network.