Registering Your Site for Electronic Data Exchange with CAIR2

The CDPH Gateway/CAIR2 IZ Portal manages electronic data exchange for all Sites in the legacy CDPH CAIR regions (including Northern California, Greater Sacramento, Bay Area, Central Coast, Central Valley, LA-Orange, Inland Empire, and Imperial regions).

Providers in the following counties: Alpine, Amador, Calaveras, Mariposa, Merced, San Diego, San Joaquin, Stanislaus, and Tuolumne cannot use the CDPH Gateway/CAIR2 IZ Portal to sign up for immunization data exchange with CAIR. If you are a provider in one of the above counties, click here for more information.

1. Go to at https://igs.cdph.ca.gov/cair/ and click Register.
2. Select a data exchange **Site Type**. Consult with your EMR vendor if you are unsure which site type to select. See **Appendix** for additional guidance on Site Type.

3. Enter your **site information**, **site contact information**, and **responsible clinician information**. VFC sites must enter a VFC PIN. All fields in red are required.

### Site Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAIR Provider ID (Please do not use ACL e-mail addresses)</td>
<td></td>
</tr>
<tr>
<td>Site Name</td>
<td></td>
</tr>
<tr>
<td>Current Site NPI</td>
<td></td>
</tr>
<tr>
<td>Site Address (Line 1)</td>
<td></td>
</tr>
<tr>
<td>Site Address (Line 2)</td>
<td></td>
</tr>
<tr>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Choose Site Type</td>
<td></td>
</tr>
<tr>
<td>Site Phone</td>
<td></td>
</tr>
<tr>
<td>FAX</td>
<td></td>
</tr>
<tr>
<td>Site Email</td>
<td></td>
</tr>
<tr>
<td>Re-type Email</td>
<td></td>
</tr>
<tr>
<td>CAIR Provider ID</td>
<td></td>
</tr>
<tr>
<td>VFC Site PIN</td>
<td></td>
</tr>
</tbody>
</table>

### Site Contact Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
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<tr>
<td>Email</td>
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<tr>
<td>Re-type Email</td>
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</tbody>
</table>

### Responsible Clinician

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
</tr>
<tr>
<td>CA Medical or Pharmacy Lic.</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td></td>
</tr>
</tbody>
</table>

If VFC, please enter VFC PIN number:
4. Enter your **data exchange information** including EMR software, EMR vendor, and EMR vendor contact. All fields in **red** are required.

**Data Exchange Information**
- What is the name (version) of the EMR/EHR software used by this office?
- Which vendor developed the EMR/EHR software used by this office?
- Can this EMR/EHR send HL7 formatted data?

**Data Exchange/Vendor Contact Information**
- DE/Vendor Contact First Name:
- DE/Vendor Contact Last Name:
- Company:
- Position:
- Phone:
- Email:
- Retype Email:

5. **Click Continue.**

Please review and correct (if necessary) the data you have entered in this form, then click Continue. To clear the form, press Reset.

6. **Review and e-sign the CAIR Organization Access & Confidentiality Agreement.**

**CAIR Organization Access & Confidentiality Agreement**

The California Immunization Registry (CAIR) is a computer-based tracking system developed to assist medical providers and other approved agencies to track and review immunization information and TB test results for individuals, assess immunization needs and remind/recall patients, avoid unnecessary or results with other CAIR users. Written disclosure is highly recommended.

6. Report any activity that may compromise the protection and privacy of the information in CAIR.

**PLEASE Do not click on your browsers back button as this could corrupt your current application.**

- By clicking this box and entering your Name as the authorized Organization Representative, you agree that the your Organization will abide by the CAIR rules set forth in this Agreement. CAIR reserves the right to terminate this agreement if the Organization or any of its staff violate the Agreement or use the system in an unauthorized manner. This Agreement will remain in effect until terminated by either party.

**Name of Organization Representative:**

**Title of Organization Representative:**

**Complete Site Registration**
7. The confirmation page displays and a verification email is sent to the site email.

8. To complete the registration process, click on the link to verify your enrollment.

9. The site email and site contact will receive a secure email with site credentials. Provide the SOAP Envelope Credentials (if populated), CAIR Org Code, and CAIR Region Code to your EMR vendor.
Appendix

The data exchange **Site Type** depends on how the site will submit data to CAIR: directly, indirectly, or as a data aggregator.

Select **Site Type [1]** if your EMR submits data **directly** to CAIR. EMR vendors that submit data directly to CAIR include, but are not limited to, Meditab, Meditech, and NextGen.

Site Intends to (choose one):

- [1] Submit immunization data directly to the CAIR Portal

Select **Site Type [2]** if your EMR submits data **indirectly** to CAIR. EMR vendors that submit data indirectly to CAIR include, but are not limited to, AllScripts, athenahealth, Cerner, eClinicalWorks, Greenway, Office Ally, Office Practicum, Practice Fusion, PrescribeWellness/SMP, and STC. Enter the **Sending Facility ID** provided by your EMR vendor if known.

Site Intends to (choose one):

- [1] Submit immunization data directly to the CAIR Portal
- [2] Submit immunization data through a Sending Facility (HIO, Vendor data warehouse, your organizations central server, etc.)
- [3] Submit immunization data as a Sending Facility (HIO, Vendor data warehouse, your organizations central server, etc.) for multiple sites.

Enter the Sending Facility ID of your Data Submitter if known:

SF-000001

Will this facility be formatting messages for your clients?

YES

Select **Site Type [3]** if you are an **EMR vendor** or a large **data aggregator** (e.g. a hospital system). Please email [CAIRdataexchange@cdph.ca.gov](mailto:CAIRdataexchange@cdph.ca.gov) prior to registering.

Site Intends to (choose one):

- [1] Submit immunization data directly to the CAIR Portal
- [2] Submit immunization data through a Sending Facility (HIO, Vendor data warehouse, your organizations central server, etc.)
- [3] Submit immunization data as a Sending Facility (HIO, Vendor data warehouse, your organizations central server, etc.) for multiple sites.

Will this facility be formatting messages for your clients?

YES

Still unsure which site type to select? Please consult your EMR vendor or email [CAIRdataexchange@cdph.ca.gov](mailto:CAIRdataexchange@cdph.ca.gov) and provide your site name, address, and EMR vendor.
### Sample Completed Form

**Site Intends to (choose one):**
- [x] Submit immunization data directly to the CAIR Portal
- [ ] Submit immunization data through a Scheduling Facility (HIO, Vendor data warehouse, your organization's central server, etc.)
- [ ] Submit immunization data as a Scheduling Facility (HIO, Vendor data warehouse, your organization's central server, etc.) for multiple sites

Enter the Sending Facility ID of your Data Submitter if known: SF-000000

Will this facility be formatting messages for your clients? YES

#### Site Information

**CAIR Provider ID:** (Please use your CAIR Provider ID as assigned)
**Site Name:** My Clinic Name
**Current Site NPI:** 1234567890
**NPI Number Lookup:**
**Site Address (Line 1):** 650 West Main Street
**Site Address (Line 2):**
**City:** Los Angeles
**County:** Los Angeles
**ZIP Code:** 00010
**Choose Site Type:** Family Practice
**Site Phone:** 213-888-7777
**FAX:** 213-555-9999
**Site Email:** site_email@email.com
**Retype Email:** site_email@email.com

**Approximate number of vaccinations anticipated by this site per month:** 100

#### Site Contact Information

**First Name:** Grizzly
**Last Name:** Bear
**Title:** Office Manager
**Phone:** 213-333-7777
**Email:** office_manager@email.com
**Retype Email:** office_manager@email.com

**Responsible Clinician**
**First Name:** Izzy
**Last Name:** Bear
**Title:** MD
**CA Medical or Pharmacy Lic. Number:** A000001
**If VFC, please enter VFC PIN number:** 654321

#### Data Exchange Information

What is the name (+version) of the EMR/EHR software used by this office? Software

Which vendor developed the EMR/EHR software used by this office? Software Vendor

Can this EMR/EHR send HL7 formatted data? YES

#### Data Exchange/Vendor Contact Information

**DE/Vendor Contact First Name:** EHR Vendor Contact First Name
**DE/Vendor Contact Last Name:** EHR Vendor Contact Last Name
**Company:** EHR Vendor
**Position:** Customer Support

**Phone:** 888-333-2222
**Email:** help@ehrvendor.com
**Retype Email:** help@ehrvendor.com

Please review and correct (if necessary) the data you have entered in this form, then click Continue. To clear the form, press Reset.