



Electronic and Manual Reporting Registration Form

Instructions:

Licensed independent practitioners (LIPs) holding the following credentials, who diagnose or treat neurodegenerative disease patients, **are required** to report: Doctor of Medicine (MD), Doctor of Osteopathy (DO), Physician's Assistant (PA), and Nurse Practitioner (NP).

Other LIPs, including advanced practice registered nurses, home care nurses, physical/occupational/speech therapists, chiropractors, podiatrists, acupuncturists, and optometrists **are not required** to report.

If LIPs work in a group practice, have a formalized relationship within the practice, or are part of a hospital or facility medical staff, the encounter reporting can be performed by the hospital or facility. A single report may constitute encounter data from multiple LIPs.

Please fill in the following registration information that includes specific contact information, inclusive of a lead physician contact, and a technical interface contact, as well as EHR vendor information for the purpose of on-boarding. If you have questions regarding this form or around the reporting requirements please contact us at: **CDSRBHelp@cdph.ca.gov**

Organization Name and Address:

Number of Represented Neurologists:

Are you currently reporting Parkinson's Data: Yes No
Will you be reporting Multiple sclerosis (MS) Data: Yes No

Lead Physician Contact

Title:	First Name:	Last Name:	Email:	Phone:
<input style="width: 40px;" type="text"/>	<input style="width: 220px;" type="text"/>	<input style="width: 220px;" type="text"/>	<input style="width: 200px;" type="text"/>	<input style="width: 100px;" type="text"/>

Lead Technical Contact

Title:	First Name:	Last Name:	Email:	Phone:
<input style="width: 40px;" type="text"/>	<input style="width: 220px;" type="text"/>	<input style="width: 220px;" type="text"/>	<input style="width: 200px;" type="text"/>	<input style="width: 100px;" type="text"/>

Lead Software Vendor Contact

Title:	First Name:	Last Name:	Email:	Phone:
<input style="width: 40px;" type="text"/>	<input style="width: 220px;" type="text"/>	<input style="width: 220px;" type="text"/>	<input style="width: 200px;" type="text"/>	<input style="width: 100px;" type="text"/>

Lead Administrative/Business Management Contact

Title:	First Name:	Last Name:	Email:	Phone:
<input style="width: 40px;" type="text"/>	<input style="width: 220px;" type="text"/>	<input style="width: 220px;" type="text"/>	<input style="width: 200px;" type="text"/>	<input style="width: 100px;" type="text"/>

Represented: Neurologist Doctor of Osteopathy Physician's Assistant Nurse Practitioner

First Name:	Last Name:	CA Physician License Number:
<input style="width: 280px;" type="text"/>	<input style="width: 270px;" type="text"/>	<input style="width: 300px;" type="text"/>
First Name:	Last Name:	CA Physician License Number:
<input style="width: 280px;" type="text"/>	<input style="width: 270px;" type="text"/>	<input style="width: 300px;" type="text"/>
First Name:	Last Name:	CA Physician License Number:
<input style="width: 280px;" type="text"/>	<input style="width: 270px;" type="text"/>	<input style="width: 300px;" type="text"/>
First Name:	Last Name:	CA Physician License Number:
<input style="width: 280px;" type="text"/>	<input style="width: 270px;" type="text"/>	<input style="width: 300px;" type="text"/>

Data Submission Method

Electronic Interface Web Portal (Manual Reporting)

Vendor Information (500 characters max, EHR and Interface Engine etc.)