

MEANINGFUL USE QUESTIONNAIRE

Physician(s): _____

Group Name: _____

Address: _____

City

State

Zip

Phone: _____

1. Are you participating in Meaningful Use (MU)? Yes No

- If No, what are your plans? _____

2. What EMR are you using? _____

- What version? _____

3. Which HISP provider are you using? _____

4. Do you have direct messaging capabilities? Yes No

- If Yes, what is the address: _____

5. IT Person Contact:

- Name: _____

- Phone: _____

- Email: _____

6. EMR Contact:

- Name: _____

- Phone: _____

- Email: _____

Please fax completed form to: 214-345-6519