

LETTER OF COMMITMENT

As a provider practicing in Nebraska who is interested in assistance in the HIT adoption process, I am interested in working with Wide River Technology Extension Center, a CIMRO of Nebraska enterprise, to achieve meaningful use to improve the efficiency and quality of my practice. I understand that this project is voluntary and I can decline participation without any financial penalty.

The Office of the National Coordinator for Health Information Technology has issued grant funding to support the adoption of Health Information Technology (HIT). This grant funding, used to establish and operate Health Information Technology Regional Extension Centers, will support priority providers who wish to adopt and meaningfully use HIT to improve care. As the Regional Extension Center for Nebraska, Wide River Technology Extension Center's goal is to assist providers with existing EHRs and those using paper systems to select, successfully implement and optimize their electronic health record (EHR) systems and achieve meaningful use of HIT. Subsidies are available for small primary care practices.

Practice/Clinic/Hospital Name and City

NPI Number

Provider Signature or Authorized Representative

Email Address

Print Name

Date

Current System:

_____ Existing EHR

_____ Paper System

Phone Number

Practice Size:

_____ 1 to 10 providers (MD, DO, PA, NP)

_____ Greater than 10 providers

Practice Type:

_____ Primary Care (FP, IM, Peds, OB/GYN)

_____ Specialty

Return completed form by fax (402) 476-1707 or email to info@widerivertec.org. For questions or additional information contact Greg Schieke at gschieke@widerivertec.org.

Page 2: (For Practice Managers to fill out on behalf of an entire clinic group.)

Number of practitioners with prescribing privileges in practice (i.e. MD, DO, PA, NP): _____

Provider Name/Credentials	NPI #	Specialty
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____
15. _____	_____	_____

Please complete additional sheets for more providers.

Authorized Representative Signature

Title

Printed Name

Date