VACCINES FOR CHILDREN (VFC) PROGRAM PROVIDER PROFILE FORM—SUPPLEMENTAL

PIN (6 digit)	
COUNTY	

NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.		DATE	
ADDRESS *(Number and Street)*		CITY	ZIP CODE
CONTACT PERSON	EMAIL ADDRESS	TELEPHONE ( )	FAX ( )

LAST NAME, FIRST, MI	NATIONAL PROVIDER IDENTIFIER (NPI)	MEDICAL LICENSE NUMBER	TITLE (e.g., MD, DO, NP, PA–Provider must have prescription writing privileges)	SPECIALITY (e.g., Peds, Family Med, GP, Other [Specify])
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Instructions: You must use this form to list all health care providers at your facility with prescription writing privileges who will administer VFC Program-provided vaccines. (You may use additional copies of this form to list additional providers.) Submit this form with the VFC Provider Profile Form.

Note: It is not necessary to include the names of all staff who may administer VFC vaccine, but rather only those who possess a medical license or are authorized to write prescriptions.