



**VACCINES FOR CHILDREN (VFC) PROGRAM  
ENROLLMENT REQUEST FAX TO: (877) 329-9832**

**Enrolling in VFC is as simple as following these steps!**

**1. Request an enrollment packet.** You may submit this enrollment request by faxing VFC's Toll-free number (877) 329-9832 and provide the following information. Please allow 5 business days for the processing of your request.

- Your practice name and mailing address
- Contact person and phone numbers (including your FAX number and e-mail address if available)
- Practice type (public or private) and practice specialty

**2. Complete enrollment forms.** Upon receipt of your VFC Enrollment Packet, please review, complete, and sign your enrollment forms. The Provider Enrollment Form must be signed by the physician-in chief or the clinic's medical director. Organizations with multiple facilities must complete enrollment forms for each of their sites. Please mail forms to:

**California Vaccines for Children (VFC) Program  
Attn: New Enrollments  
850 Marina Bay Parkway, Building P, Second Floor  
Richmond, CA 94804**

**3. Schedule a site visit review.** Within 2 weeks of the receipt of your forms, you will be contacted by your local VFC Representative to arrange a New Provider Enrollment site visit and approve your facility for enrollment in our program.

**4. Submit your first vaccine order.** Once your site is approved, you will receive a "VFC Welcome Packet" which will include your new VFC Provider Identification Number or PIN. You will need this number for all interactions with the VFC Program. Once your new PIN number is assigned, VFC will process your first vaccine order.

**If you are interested in joining the California Vaccines for Children (VFC) Program, please complete this Provider Enrollment Request.**

TYPE OF ENROLLMENT REQUEST		<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Re-enrollment Request	<input type="checkbox"/> Currently enrolled in VFC, but requesting own Provider Identification Number (PIN)	DATE
PRACTICE NAME			CONTACT PERSON FOR VFC ENROLLMENT		
FACILITY MAILING ADDRESS (Number, Street and ZIP—No P.O. Boxes)			CITY	ZIP CODE	
TELEPHONE:	FAX:	EMAIL:		COUNTY:	

Are immunizations currently available at this practice?  Yes  No

Please Indicate the Type of Facility	
<p><b>Public</b></p> <p><input type="checkbox"/> Local Health Department Clinic</p> <p><input type="checkbox"/> Federally Qualified Health Center or Rural Health Clinic</p> <p><input type="checkbox"/> Hospital</p> <p><input type="checkbox"/> School/University</p> <p><input type="checkbox"/> Other (Please specify): _____</p>	<p><b>Private</b></p> <p><input type="checkbox"/> Private Practice (Individual or Group)</p> <p><input type="checkbox"/> School/University</p> <p><input type="checkbox"/> Hospital</p> <p><input type="checkbox"/> Other (Please specify): _____</p>

Please Indicate Practice Specialty
<p><input type="checkbox"/> Pediatrics Family    <input type="checkbox"/> Family Practice    <input type="checkbox"/> Intern. Medicine    <input type="checkbox"/> Multi-specialty    <input type="checkbox"/> OB/GYN/ Women's Health</p> <p><input type="checkbox"/> Other (Please specify): _____</p>

*Thank you for your enrollment request. Please allow 5 business days for the processing of your request.*