VACCINES FOR CHILDREN (VFC) PROGRAM PROVIDER RECERTIFICATION FORM

Note: Use this form only if you cannot update your information online. Refer to the printout and only update fields that are incorrect. When finished, print, sign, and mail to the **CA VFC Program, 850 Marina Bay Parkway, Richmond CA 94804**

It is a federal requirement that each enrolled site to which VFC Program vaccines will be delivered must complete and submit this form with a VFC Program Profile-Supplemental Form (CDPH 84995) to the address below at least once a year to receive VFC-supplied vaccine. Each enrolled site also must submit a Provider Profile Form and Profile-Supplemental Form whenever (1) the estimated of eligible children to be served changes; (2) the status of the facility changes (e.g., a private provider becomes an agent of a federally qualified health center, etc.), or the persons with prescription-writing privileges changes.

| Practice Information/Shipping | | | | | |
|--|---|--|--|---|--|
| NAME | PIN: | | | | |
| Vaccine Delivery / Shipping Address (No P.O. Box) | | CITY: | | ZIP | |
| Vaccine Delivery Address, Part 2 | | COUNTY | | | |
| CONTACT PERSON: | NATIONAL PROVIDER IDEN | TIFIER (NPI): | PHONE | | FAX |
| EMPLOYER IDENTIFICATION NUMBER (EIN) | EMAIL ADDRESS: | | I | | |
| CHDP PROVIDER?: Yes No | MEDI-CAL PROVIDER?: | | PUBLIC SITE?: | Yes C |) No |
| PROVIDER TYPE: Public health department Public health hospital Fed. qual. hlth center/ rural hlth Private | practice (individual or group) | Specialty or 'Specialty Pediatrics Family practic Internal medic | Multisped e Ob/Gyn | Ŏ I | School-based clinic Pharmacy Other |
| Mailing Address | | | | | |
| CONTACT PERSON: | | CITY: | | | |
| MAILING ADDRESS: | ZIP: | | | | |
| MAILING ADDRESS, PART 2 | | | | | |
| Vaccine Storage Units | | | | | |
| vaccine storage office | | | | | |
| INDICATE YOUR REFRIGERATOR STORAGE UNIT TYP | ES BELOW: | INDICATE YOUR FREE | ZER STORAGE UNIT | T TYPES BELOW: | |
| 9 | Number of Units: macy grade Number of Units: | Type: Small/under co No varicella Type: Small/under co No varicella Type: Small/under co No varicella | ounter Comb | TTYPES BELOW: Dination mercial/pharmacy Dination mercial/pharmacy | Number of Units: |
| INDICATE YOUR REFRIGERATOR STORAGE UNIT TYPE: Small/under counter Combination Stand alone refrigerator Commercial/phare Type: Small/under counter Combination | Number of Units: macy grade Number of Units: macy grade | Type: Small/under co Stand alone fro No varicella Type: Small/under co Stand alone fro No varicella | ounter Comb | oination mercial/pharmacy oination | y grade Number of Units: |
| Type: Stand alone refrigerator Small/under counter Stand alone refrigerator Small/under counter Stand alone refrigerator Combination Combination Combination Stand alone frrezer Commercial/phare | Number of Units: macy grade Number of Units: macy grade yrs who are VFC-eligible? | Type: Small/under co Stand alone fro No varicella Type: Small/under co Stand alone fro No varicella W (Note: Do not cour | ounter Combeezer Combeezer Combeezer Comm | pination mercial/pharmacy pination mercial/pharmacy | y grade Number of Units: |
| Type: Small/under counter Stand alone refrigerator Small/under counter Stand alone refrigerator Small/under counter Small/under counter Small/under counter Stand alone frrezer Commercial/phant Patient Estimates 1. Please estimate the % of patients 0-18 2. Estimated number of children who with | Number of Units: macy grade Number of Units: macy grade yrs who are VFC-eligible? | Type: Small/under co Stand alone fro No varicella Type: Small/under co Stand alone fro No varicella W | ounter Combeezer Commounter Commounter Commounter Ages | pination mercial/pharmacy pination mercial/pharmacy | Number of Units: |
| Type: Small/under counter Stand alone refrigerator Small/under counter Small/under counter Small/under counter Small/under counter Small/under counter Small/under counter Stand alone frrezer Combination Commercial/phare Patient Estimates 1. Please estimate the % of patients 0-18 2. Estimated number of children who we at your practice or clinic for a 12-month page 12-month page 13-month page 13-month page 14-month pa | Number of Units: macy grade Number of Units: macy grade yrs who are VFC-eligible? | Type: Small/under co Stand alone fro No varicella Type: Small/under co Stand alone fro No varicella W (Note: Do not cour | ounter Combeezer Combeezer Combeezer Comm | pination mercial/pharmacy pination mercial/pharmacy | Number of Units: |
| Type: Small/under counter Stand alone refrigerator Small/under counter Stand alone refrigerator Small/under counter Small/under counter Small/under counter Small/under counter Small/under counter Stand alone frrezer Commercial/phare Patient Estimates 1. Please estimate the % of patients 0-18 2. Estimated number of children who was at your practice or clinic for a 12-month part of the counter of the counte | Number of Units: macy grade Number of Units: macy grade yrs who are VFC-eligible? | Type: Small/under co Stand alone fro No varicella Type: Small/under co Stand alone fro No varicella W (Note: Do not cour | ounter Combeezer Combeezer Combeezer Comm | pination mercial/pharmacy pination mercial/pharmacy | Number of Units: |
| Type: Small/under counter Stand alone refrigerator Stand alone refrigerator Stand alone frrezer Combination Commercial/phare Type: Small/under counter Stand alone frrezer Commercial/phare Commercial/phare Patient Estimates 1. Please estimate the % of patients 0-18 2. Estimated number of children who we at your practice or clinic for a 12-month part a. CHDP/Medi-Cal Eligible b. Without Private Insurance | Number of Units: macy grade Number of Units: macy grade yrs who are VFC-eligible? | Type: Small/under co Stand alone fro No varicella Type: Small/under co Stand alone fro No varicella W (Note: Do not cour | ounter Combeezer Combeezer Combeezer Comm | pination mercial/pharmacy pination mercial/pharmacy | Number of Units: |

| List of Health Care Providers with Prescription Writing Privileges | | | | | | | |
|--|---|------------|-------------------------------|-----------------------------------|---------------|----------------------|--|
| Instructions: se this form to list all health care providers at your facility with prescription writing privileges who will administer VFC Program-provided vaccines. 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. | | | | | | | |
| # | Last Name | First Name | National Provider ID (NPI) | Medical License Number | Title | Specialty code | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| = | -mail Commur | nication | | | | | |
| To keep up with changing needs of our providers, the CA VFC Program is planning for future methods of communicating with providers. Email communication would be more timely — immediate compared to several days for a FAXblast or regular mail — and involve less paper to file. | | | | | | | |
| | ur practice would be ess on the line below | | ng VFC Program communications | by email, signify your interest k | oy entering y | your preferred Email | |
| Preferred E-mail Address for VFC communication | | | | | | | |

If your practice is <u>is interested but does not currently have an e-mail address</u>, check this box:

VFC Agreement

To participate in the Vaccines for Children (VFC) Program and receive federally procured vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department, or other health delivery facility of which I am the physician-in-chief or equivalent:

- 1. I will screen patients and administer VFC Program-purchased vaccine only to a child who is 18 years of age or younger who qualifies under one or more of the following categories:
 - a. Is an American Indian or Alaskan Native;
 - b. Is eligible for California's Child Health and Disability Prevention (CHDP) Program or Medi-Cal Program; or
 - c. Has no health insurance.

Note: Children with private health insurance and Healthy Family subscribers are not eligible for VFC vaccines.

- 2. I will maintain a record of each VFC-enrolled child's required information on VFC eligibility screening for a period of three (3) years. Release of such records will be bound by the privacy protection of the federal Medicaid law.
- 3. If requested, I will make such records available to the State or the Department of Public Health (DPH).
- 4. I will permit visits to my facility by authorized representatives of the State or DHHS to review my compliance with VFC Program requirements including vaccine storage and record-keeping.
- 5. I will administer VFC vaccines only to children in eligible age cohorts for each vaccine, as set by the Advisory Committee on Immunization Practices (ACIP) in VFC resolutions.
- 6 I will administer all age-appropriate immunizations to patients in my practice in compliance with the recommended immunization schedule, dosage, and contraindications that are established by the ACIP, unless:
 - a. In my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or
 - b. The particular requirement contradicts the law in my State pertaining to religious and other exemptions.
- 7. I will distribute written vaccine information (e.g. Vaccine Information Statements [VISs]) and maintain records in accordance with the National Childhood Vaccine Injury Act.
- 8. I will not impose a charge for the cost of the vaccine.
- 9 I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the State. (The current maximum for the State of California is \$17.55 per dose administered.)
- 10. I will not deny administration of a federally procured vaccine to a child because the child's parent or guardian or individual of record is unable to pay the administration fee.
- 11. I will comply with the State's requirements for ordering vaccine as outlined on VFC order forms, etc. (e.g., reporting via the order forms my previous VFC vaccine usage and my current inventory of VFC vaccine, ordering vaccine according to the order frequency category identified for my practice, etc.)
- 12. I will be financially responsible for the replacement cost of any VFC-provided vaccines that I receive for which I cannot account or that spoil or expire because of negligence.
- 13. I agree to store and handle VFC-supplied vaccines in accordance with the manufacturer's specifications and only at the facility stipulated in this agreement. I may be required to purchase a new refrigerator or freezer unit if equipment at my practice is deemed inappropriate for vaccine storage or not able to maintain appropriate temperature.
- 14. I will use the VFC provided Fahrenheit (F°) Temperature Log or Celsius (C°) Temperature Log on all cold storage units that contain vaccines, and retain the "Temp Log" (IMM-682) record each month for a period of thirty six (36) months.
- 15. I understand the State may terminate this agreement at any time for failure to comply with these requirements or without cause.

Note: I understand that if this agreement is terminated, I must return to the VFC Program all unused (viable and non-viable) VFC vaccine. I also will comply with the VFC Program's procedures for return of the vaccine.

To agree to these federal requirements, type your name, your medical license number, today's date, and sign in the boxes below.

| Chief Physician Name (print) | Medical License Number | Date: |
|------------------------------|------------------------|-------|
| | | |
| Chief Physician (signature) | | |
| | | |
| | | |