

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)