Reset

VACCINES FOR CHILDREN PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION

Facility Name:			VFC Pin#:
Facility Address:			
City:	County:	State: HI	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State: HI	Zip:

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official VFC-registered health care provider signing the agreement must be a practitioner authorized to administer pediatric vaccines* under state law, who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*

**Note: For the purposes of the VFC program, the term 'vaccine' is defined as any FDA-authorized or licensed, ACIP-recommended product for which ACIP approves a VFC resolution for inclusion in the VFC program.*

Last Name, First, MI:		Title:
Specialty:	License No:	Medicaid or NPI No:
Employer Identification Number:		Email:

VFC VACCINE COORDINATOR

Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ◯ Yes ◯ No	Type of training received:
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ◯ Yes ◯ No	Type of training received: