VACCINES FOR CHILDREN (VFC) PROGRAM

2017 VFC RECERTIFICATION WORKSHEET

Use this worksheet to gather information needed ahead of time to complete the online VFC Recertification Form on MyVFCvaccines.org.

DO NOT SUBMIT THIS WORKSHEET TO THE VFC PROGRAM.

Practice Information/Shipping

Practice Name		Contact Person	PIN
Practice Information/Shipping Address (No P.O. Box)		County	Registry ID
Shipping Address, Part 2		City	ZIP
Employer Identification Number (EIN)	National Provider Identifier (NPI)	Phone	Fax
CHDP Provider? ◯ Yes ◯ No	MEDI-CAL Provider? ◯ Yes ◯ No	Would you like to be on the VFC online locator? ◯ Yes ◯ No	

DELIVERY: Check all days and times you may receive vaccine. If closed during lunch hour, please specify

Tuesday	From:	To:	(Closed for lunch from:	to:	)
Wednesday	From:	To:	(Closed for lunch from:	to:	)
Thursday	From:	To:	(Closed for lunch from:	to:	)
Friday	From:	To:	(Closed for lunch from:	to:	)

Key Practice Staff

Role/Responsibility	Name	Title (MD,DO, NP,PA, PharmD)	Specialty/Clinic Title	National Provider ID	Medical License #	Contact Information
Provider of Record			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email: _____
Vaccine Coordinator			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email: _____
Backup Vaccine Coordinator			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email: _____
Provider of Record Designee			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email: _____

2017 VFC RECERTIFICATION WORKSHEET

DO NOT SUBMIT THIS WORKSHEET TO THE VFC PROGRAM.

Vaccine Storage Units & Temperature Monitoring Equipment Information

Indicate information for your **REFRIGERATOR** storage unit below:

Unit Location/ID	**Use** ◯ Primary ◯ Day Use ◯ Backup/Overflow	**Refrigerator Type** ◯ Under Counter ◯ Combination ◯ Stand-alone	
Brand, Model	**Storage Capacity (in cubic feet)**	**Grade** ◯ Household ◯ Commercial ◯ Pharmacy/Laboratory/Biologic	

Thermometer Type

◯ Digital MIN/MAX Thermometer ◯ Data Logger/Continuous Temperature Monitoring Device ◯ Other_____

Thermometer Model	**Thermometer Serial Number**	**Calibration Expiration Date**

Indicate information for your **FREEZER** storage unit below:

Unit Location/ID	**Use** ◯ Primary ◯ Day Use ◯ Backup/Overflow Use	**Freezer Type** ◯ Upright Freezer ◯ Combination ◯ Chest Freezer	
Brand, Model	**Storage Capacity (in cubic feet)**	**Grade** ◯ Household ◯ Commercial ◯ Pharmacy/Laboratory/Biologic	

Thermometer Type

◯ Digital MIN/MAX Thermometer ◯ Data Logger/Continuous Temperature Monitoring Device ◯ Other_____

Thermometer Model	**Thermometer Serial Number**	**Calibration Expiration Date**

Indicate information for your **BACKUP THERMOMETER** below:

Thermometer Type

◯ Digital MIN/MAX Thermometer ◯ Data Logger/Continuous Temperature Monitoring Device ◯ Other_____

Thermometer Model	**Thermometer Serial Number**	**Calibration Expiration Date**

2017 VFC RECERTIFICATION WORKSHEET

DO NOT SUBMIT THIS WORKSHEET TO THE VFC PROGRAM.

Patient Population

Estimated number of children who will receive immunizations at your practice or clinic for a 12-month period, by category:	Ages (Note: Do not count a child in more than one category.)			TOTAL
	<1 yr	1–6 yrs	7–18 yrs	
TOTAL VFC-ELIGIBLE				
a. CHDP/Medi-Cal Eligible				
b. Uninsured				
c. American Indian or Alaskan Native				
d. Underinsured (FQHCs | RHCs only)				
NON-VFC ELIGIBLE				
TOTAL OF ALL CHILDREN (VFC-ELIGIBLE AND NON-VFC ELIGIBLE)				

What data source was used to determine patient estimates?

- ○ Billing info
- ○ Usage Logs
- ○ Electronic Health Records
- ○ Provider Encounter Data
- ○ CAIR/Registry
- ○ Patient Log
- ○ Medi-Cal Claims Data
- ○ Other _____

ACIP Recommended Vaccines Offered

Indicate all age-appropriate ACIP-recommended vaccines your practice will offer:

☐ *I certify that my practice will order and provide all age-appropriate ACIP-recommended vaccines to my VFC-eligible patient populations. Below are the age-appropriate ACIP-recommended vaccines that I will provide based on my patient estimates.*

- ○ Hep B
- ○ Rotavirus
- ○ DTaP
- ○ Hib
- ○ PCV13
- ○ IPV
- ○ Influenza
- ○ MMR
- ○ Varicella
- ○ Hep A
- ○ Tdap
- ○ HPV
- ○ Meningococcal
- ○ Td

List of Health-Care Providers with Prescription-Writing Privileges

Instructions: *Use this form to list all health-care providers at your facility with prescription-writing privileges who will administer VFC supplied 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
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

VACCINES FOR CHILDREN (VFC) PROGRAM

SUPPLEMENTAL PAGE FOR ADDITIONAL VACCINE STORAGE UNIT & TEMPERATURE MONITORING EQUIPMENT INFORMATION

DO NOT SUBMIT THIS WORKSHEET TO THE VFC PROGRAM.

If you have additional vaccine storage units and/or thermometers, indicate the information below.

Indicate information for your **REFRIGERATOR** storage unit below:

Unit Location/ID	**Use** ◯ Primary ◯ Day Use ◯ Backup/Overflow	**Refrigerator Type** ◯ Under Counter ◯ Combination ◯ Stand alone	
Brand, Model	**Storage Capacity (in cubic feet)**	**Grade** ◯ Household ◯ Commercial ◯ Pharmacy/Laboratory/Biologic	

Thermometer Type

◯ Digital MIN/MAX Thermometer ◯ Data Logger/ Continuous Temperature Monitoring Device ◯ Other_____

Thermometer Model	**Thermometer Serial Number**	**Calibration Expiration Date**

Indicate information for your **FREEZER** storage unit below:

Unit Location/ID	**Use** ◯ Primary ◯ Day Use ◯ Backup/Overflow Use	**Freezer Type** ◯ Upright Freezer ◯ Combination ◯ Chest Freezer	
Brand, Model	**Storage Capacity (in cubic feet)**	**Grade** ◯ Household ◯ Commercial ◯ Pharmacy/Laboratory/Biologic	

Thermometer Type

◯ Digital MIN/MAX Thermometer ◯ Data Logger/ Continuous Temperature Monitoring Device ◯ Other_____

Thermometer Model	**Thermometer Serial Number**	**Calibration Expiration Date**

Indicate information for your **BACKUP THERMOMETER** below:

Thermometer Type

◯ Digital MIN/MAX Thermometer ◯ Data Logger/ Continuous Temperature Monitoring Device ◯ Other_____

Thermometer Model	**Thermometer Serial Number**	**Calibration Expiration Date**