Vaccines for Adults & Local Health Department 317 Programs

RECERTIFICATION WORKSHEET

Use this worksheet to gather information needed ahead of time to complete the online VFA or LHD 317 Recertification Form on myCAvax.cdph.ca.gov. The fields highlighted in yellow below indicate this information will be migrated and prepopulated from MyVFCVaccines.

DO NOT SUBMIT THIS WORKSHEET TO THE VFA or LHD 317 PROGRAMS.

Step 1–Practice Information/Shipping

Practice Name	myCAvax ID:	PIN	Registry ID
Practice Information/Shipping Address (No P.O. Box)		City	ZIP
Shipping Address, Part 2		County	
Employee Identification Number (EIN)	National Provider Identifier (NPI)	Phone	Fax
MEDI-CAL Provider? ☐Yes ☐No	For Federally Qualified Health Centers (FQHC) ONLY, name of Parent FQHC Organization:		

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

☐ **Monday**	From:	To:	(Closed for lunch from:	to:	)
☐ **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:	)

Step 2 – 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 for program updates: _____
Vaccine Coordinator *(For VFA Providers, this staff member was previously identified as the VFA Contact. For LHD 317, this staff member was previously the Primary Vaccine Coordinator).*			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____
Backup Vaccine Coordinator			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____
Provider of Record Designee			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____
Additional Staff Members *(Staff who will receive program communications)*			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____

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Step 3 – Storage Units

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

Enter all units that will be used to store VFA or LHD 317 vaccines and indicate at least one unit as the primary storage unit for vaccines.
Existing storage units from other programs are available to view and add to VFA or LHD 317 if storing in the same unit. Brand new units need to be added by completing the information below in myCAvax.

Refrigerator Type: ☐ Compact ☐ Combination ☐ Stand-Alone ☐ Auto-Dispensing Doorless	**Unit Location/ID:**	**Brand, Model:**
Unit Priority: ☐ Primary ☐ Backup/Overflow ☐ Day Use ☐ Mobile Unit	**Unit Grade:** ☐ Household ☐ Commercial ☐ Purpose-Built (Pharmacy/Lab Grade)	**Vaccines Stored:** ☐ SGF ☐ VFA ☐ VFC ☐ BAP ☐ 317 ☐ Outbreak
Thermometer Type: ☐ Data Logger		**Storage Capacity (in cubic feet):**
Thermometer Model:	**Thermometer Serial Number:**	**Calibration Expiration Date:**

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

Freezer Type: ☐ Upright ☐ Combination ☐ Ultra-Cold ☐ Chest ☐ Auto-Dispensing Doorless	**Unit Location/ID:**	**Brand, Model:**
Unit Priority: ☐ Primary ☐ Backup/Overflow ☐ Day Use ☐ Mobile Unit	**Unit Grade:** ☐ Household ☐ Commercial ☐ Purpose-Built (Pharmacy/Lab Grade)	**Vaccines Stored:** ☐ SGF ☐ VFA ☐ VFC ☐ BAP ☐ 317 ☐ Outbreak
Thermometer Type: ☐ Data Logger		**Storage Capacity (in cubic feet):**
Thermometer Model:	**Thermometer Serial Number:**	**Calibration Expiration Date:**

Your location must have a backup thermometer to continue recertification, please indicate information for your **BACKUP THERMOMETER** below:

Thermometer Type: ☐ Data Logger		**Intention of Use:**
Thermometer Model:	**Thermometer Serial Number:**	**Calibration Expiration Date:**

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Step 4–Provider Population

Estimated number of adults 19 years of age and older who will receive immunizations in your clinic during the upcoming 12-month period

Eligibility	19-26	27-49	50-64	≥65	Total
VFA or LHD 317					
Not Eligible for VFA or LHD 317					

What data source was used to determine patient estimates? _____
Name of Electronic Health Record: _____

Step 5–Health-Care Providers with Prescription-Writing Privileges

You must have at least one medical staff listed. Medical staff are healthcare providers with prescription-writing privileges and all licenses must be verified. Health care provider medical licenses will be validated electronically. You must use this form to list all medical staff who will administer VFA or LHD 317 program-supplied vaccines. Please make sure you enter the name exactly as it appears on the medical license. Do NOT include title (e.g. MD, DO, etc.). You can verify that you have the correct license number from the CA Dept. of Consumer Affairs.

(Note: The Provider of Record listed in the VFA or LHD 317 recertification will be pre-populated.)

	Last Name	First Name	National Provider ID (NPI)	Medical License Number	Title	Specialty
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

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

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

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

Refrigerator Type: ☐ Compact ☐ Combination ☐ Stand-Alone ☐ Auto-dispensing Doorless	**Unit Location/ID:**	**Brand, Model:**
Unit Priority: ☐ Primary ☐ Backup/Overflow ☐ Day Use ☐ Mobile Unit	**Unit Grade:** ☐ Household ☐ Commercial ☐ Purpose-Built (Pharmacy/Lab Grade)	**Vaccines Stored:** ☐ SGF ☐ VFA ☐ VFC ☐ BAP ☐ 317 ☐ Outbreak
Thermometer Type: ☐ Data Logger		**Storage Capacity (in cubic feet):**
Thermometer Model:	**Thermometer Serial Number:**	**Calibration Expiration Date:**

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

Freezer Type: ☐Upright ☐ Combination ☐ Ultra-Cold ☐ Chest ☐ Auto-dispensing Doorless	**Unit Location/ID:**	**Brand, Model:**
Unit Priority: ☐ Primary ☐ Backup/Overflow ☐ Day Use ☐ Mobile Unit	**Unit Grade:** ☐ Household ☐ Commercial ☐ Purpose-Built (Pharmacy/Lab Grade)	**Vaccines Stored:** ☐ SGF ☐ VFA ☐ VFC ☐ BAP ☐ 317 ☐ Outbreak
Thermometer Type: ☐ Data Logger		**Storage Capacity (in cubic feet):**
Thermometer Model:	**Thermometer Serial Number:**	**Calibration Expiration Date:**

Your location must have a backup thermometer to continue recertification, please indicate information for your **BACKUP THERMOMETER** below:

Thermometer Type: ☐ Data Logger		**Intention of Use:**
Thermometer Model:	**Thermometer Serial Number:**	**Calibration Expiration Date:**