**VACCINES FOR CHILDREN (VFC) PROGRAM**

# PROVIDER ENROLLMENT WORKSHEET

Use this worksheet to gather information needed ahead of time to complete the online VFC Enrollment Form on https://eziz.org/vfc/enrollment/.

**DO NOT SUBMIT THIS WORKSHEET TO THE VFC PROGRAM.**

## Practice Information/Shipping

| | | | |
|---|---|---|---|
| Practice Name | | Contact Person | |
| 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.

**Tue** From: to: (Closed for lunch from: to: ) **Thur** From: to: (Closed for lunch from: to: )

**Wed** From: to: (Closed for lunch from: to: ) **Fri** From: to: (Closed for lunch from: to: )

*Note: Your practice must be open at least 4 consecutive hours for one day*

## Facility Type

PUBLIC TYPES:

- ◯ Public Health Department
- ◯ Public Health Department/FQHC
- ◯ Public Hospital
- ◯ Federally Qualified Health Center (FQHC)/ Rural Health Center (RHC)*
- ◯ Other Public Heath
- ◯ State Licensed Community Health Center (non-Federal)
- ◯ American Indian/ Tribal Health Clinic
- ◯ Youth Correctional Facilities
- ◯ School-Based Clinic
- ◯ College/University
- ◯ Family Planning/STD Clinic
- ◯ Refugee Health Center
- ◯ Migrant Health Center
- ◯ Drug Treatment Center

*If you marked FQHC or RHC you must submit a photocopy of your FQHC or RHC license/certification.*

Name of Parent FQHC: _____

or

PRIVATE TYPES:

- ◯ Private Practice (Individual or Group)
- ◯ Private Hospital
- ◯ Pharmacy
- ◯ Private Other

SPECIALTY or SPECIALTY CLINIC TYPES:

- ◯ Pediatrics
- ◯ Family Practice
- ◯ Internal Medicine
- ◯ Adolescent Health
- ◯ Multi-Specialty
- ◯ Ob/Gyn
- ◯ Family Planning
- ◯ American Indian/ Native American Health Clinic

## 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: _____ |

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**Definitions of Key Practice Staff:**

- **Provider of Record (POR):** The VFC Provider of Record is the physician-in-chief, medical director, or equivalent role that signs and agrees to the terms of the VFC "Provider Agreement" and the California VFC Program "Provider Agreement Addendum" and who is ultimately accountable for the practice's compliance. The Provider of Record must be a licensed MD, DO, NP, PA, pharmacist, or a Certified Nurse Midwife with prescription-writing privileges in California.
- **Vaccine Coordinator:** The VFC Vaccine Coordinator is an on-site employee who is fully trained and responsible for implementing and overseeing the provider's vaccine management plan. The Vaccine Coordinator might be responsible for all vaccine management activities, including training other (especially new) staff. In other practices, a different person might have one or more vaccine management responsibilities.
- **Backup Vaccine Coordinator:** The VFC Backup Vaccine Coordinator is an on-site employee who is fully trained in the practice's vaccine management activities and fulfills the responsibilities of the Vaccine Coordinator if the Vaccine Coordinator is unavailable.
- **Provider of Record Designee:** The VFC Provider of Record Designee is the on-site person that is designated by the Provider of Record to sign VFC documents on his/her behalf and assume responsibility for VFC-related matters in the absence of the Provider of Record.

**Required EZIZ Lessons:**

**Key practice staff must complete required lessons on the VFC website www.eziz.org. Completion of the lessons must occur before accessing the online VFC Enrollment Form.**

Completion of Required Lessons:

**Indicate the unique User ID and Confirmation Codes received for each key clinic staff member after completion of the required VFC Lessons.**

- VFC Program Requirements
- Storing Vaccines
- Monitoring Storage Unit Temperatures
- Provider Operations Manual (POM) Acknowledgement Lesson *(Acknowledge and Review)*
- Vaccine Management Plan *(Acknowledge and Review)*
- Conducting a Vaccine Inventory *(optional for the Provider of Record and Provider of Record Designee)*

| Role/Responsibility | User ID | Confirmation Code |
|---|---|---|
| Provider of Record | | |
| Vaccine Coordinator | | |
| Backup Vaccine Coordinator | | |
| Provider of Record Designee | | |

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## Vaccine Storage Units & Temperature Monitoring Equipment Information

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

| | | |
|---|---|---|
| **Unit Location/ID** | **Use** ◯ Primary ◯ Backup/Overflow ◯ Day Use ◯ Mobile unit | **Refrigerator Type** ◯ Compact/Under-the-Counter ◯ Stand-alone ◯ Auto-dispensing Doorless |
| **Brand, Model** | **Storage Capacity (in cubic feet)** | **Grade** ◯ Household ◯ Commercial ◯ Purpose-built (Pharmacy/Laboratory Grade) |

**Thermometer Type**

◯ Data Logger ◯ Other_____

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

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

| | | |
|---|---|---|
| **Unit Location/ID** | **Use** ◯ Primary ◯ Backup/Overflow ◯ Day Use ◯ Mobile unit | **Freezer Type** ◯ Upright Freezer ◯ Ultra-Low Temperature (ULT) ◯ Chest Freezer ◯ Auto-dispensing Doorless |
| **Brand, Model** | **Storage Capacity (in cubic feet)** | **Grade** ◯ Household ◯ Commercial ◯ Purpose-built (Pharmacy/Laboratory Grade) |

**Thermometer Type**

◯ Data Logger ◯ Other_____

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

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

**Thermometer Type**

◯ Data Logger ◯ Other_____

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

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# PROVIDER ENROLLMENT WORKSHEET

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## Provider 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) | | | | |
| PRIVATELY INSURED | | | | |
| TOTAL OF ALL CHILDREN (VFC-ELIGIBLE AND NON-VFC) | | | | |

What data source was used to determine patient estimates?

○ Billing info ○ Usage Logs ○ Electronic Health Records
○ CAIR/Registry ○ Patient Log ○ Other _____

Name of Electronic Health Record: _____

## ACIP Recommended Vaccines Offered

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

☐ *I certify that the estimates I have provided are a true reflection of my pediatric patient population according to the data source selected. Below are the age-appropriate ACIP-recommended vaccines that I will provide based on my patient estimates.*

| | | | |
|---|---|---|---|
| ○ COVID | ○ DTaP | ○ Hep A | ○ Hep B |
| ○ Hib | ○ HPV | ○ Influenza | ○ IPV |
| ○ Meningococcal | ○ MMR | ○ Pneumococcal | ○ Rotavirus |
| ○ RSV | ○ Td | ○ Tdap | ○ Varicella |

## 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 | | | | | | |

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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, indicate the information below:

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

| | | |
|---|---|---|
| **Unit Location/ID** | **Use** ◯ Primary ◯ Backup/Overflow ◯ Day Use ◯ Mobile unit | **Refrigerator Type** ◯ Compact/Under-the-Counter ◯ Stand-alone ◯ Auto-dispensing Doorless |
| **Brand, Model** | **Storage Capacity (in cubic feet)** | **Grade** ◯ Household ◯ Commercial ◯ Purpose-built (Pharmacy/Laboratory Grade) |

**Thermometer Type**

◯ Data Logger ◯ Other_____

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

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

| | | |
|---|---|---|
| **Unit Location/ID** | **Use** ◯ Primary ◯ Backup/Overflow ◯ Day Use ◯ Mobile unit | **Freezer Type** ◯ Upright Freezer ◯ Ultra-Low Temperature (ULT) ◯ Chest Freezer ◯ Auto-dispensing Doorless |
| **Brand, Model** | **Storage Capacity (in cubic feet)** | **Grade** ◯ Household ◯ Commercial ◯ Purpose-built (Pharmacy/Laboratory Grade) |

**Thermometer Type**

◯ Data Logger ◯ Other_____

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

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

**Thermometer Type**

◯ Data Logger ◯ Other_____

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

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