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**

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Contact Person</th>
<th>PIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Information/Shipping Address (No P.O. Box)</td>
<td>County</td>
<td>Registry ID</td>
</tr>
<tr>
<td>Shipping Address, Part 2</td>
<td>City</td>
<td>ZIP</td>
</tr>
<tr>
<td>Employer Identification Number (EIN)</td>
<td>National Provider Identifier (NPI)</td>
<td>Phone</td>
</tr>
</tbody>
</table>

**CHDP Provider?** ☐ Yes ☐ No  
**MEDI-CAL Provider?** ☐ 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**

<table>
<thead>
<tr>
<th>Role/Responsibility</th>
<th>Name</th>
<th>Specialty/Clinic Title</th>
<th>National Provider ID</th>
<th>Medical License #</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Provider of Record  |      | Specialties:________   |                      |                    | Direct Phone Number:________  
|                     |      | Clinic Title:________  |                      |                    | Email:________  
| Vaccine Coordinator |      | Specialties:________  |                      |                    | Direct Phone Number:________  
|                     |      | Clinic Title:________  |                      |                    | Email:________  
| Backup Vaccine Coordinator |      | Specialties:________  |                      |                    | Direct Phone Number:________  
|                     |      | Clinic Title:________  |                      |                    | Email:________  
| Provider of Record Designee |      | Specialties:________  |                      |                    | Direct Phone Number:________  
|                     |      | Clinic Title:________  |                      |                    | Email:________  |
## Vaccine Storage Units & Temperature Monitoring Equipment Information

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

<table>
<thead>
<tr>
<th>Unit Location/ID</th>
<th>Use</th>
<th>Refrigerator Type</th>
<th>Brand, Model</th>
<th>Storage Capacity (in cubic feet)</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary</td>
<td>Under Counter</td>
<td></td>
<td></td>
<td>Household</td>
</tr>
<tr>
<td></td>
<td>Day Use</td>
<td>Stand-alone</td>
<td></td>
<td></td>
<td>Commercial</td>
</tr>
<tr>
<td></td>
<td>Backup/Overflow</td>
<td>Combination</td>
<td></td>
<td></td>
<td>Pharmacy/Laboratory/Biologic</td>
</tr>
</tbody>
</table>

Thermometer Type
- Digital MIN/MAX Thermometer
- Data Logger/Continuous Temperature Monitoring Device
- Other______________________

Thermometer Model

<table>
<thead>
<tr>
<th>Thermometer Serial Number</th>
<th>Calibration Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Unit Location/ID</th>
<th>Use</th>
<th>Freezer Type</th>
<th>Brand, Model</th>
<th>Storage Capacity (in cubic feet)</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary</td>
<td>Upright Freezer</td>
<td></td>
<td></td>
<td>Household</td>
</tr>
<tr>
<td></td>
<td>Day Use</td>
<td>Chest Freezer</td>
<td></td>
<td></td>
<td>Commercial</td>
</tr>
<tr>
<td></td>
<td>Backup/Overflow Use</td>
<td>Combination</td>
<td></td>
<td></td>
<td>Pharmacy/Laboratory/Biologic</td>
</tr>
</tbody>
</table>

Thermometer Type
- Digital MIN/MAX Thermometer
- Data Logger/Continuous Temperature Monitoring Device
- Other______________________

Thermometer Model

<table>
<thead>
<tr>
<th>Thermometer Serial Number</th>
<th>Calibration Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Thermometer Type</th>
<th></th>
<th></th>
<th>Other______________________</th>
</tr>
</thead>
</table>

Thermometer Model

<table>
<thead>
<tr>
<th>Thermometer Serial Number</th>
<th>Calibration Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Patient Population

Estimated number of children who will receive immunizations at your practice or clinic for a 12-month period, by category:

<table>
<thead>
<tr>
<th>Category</th>
<th>&lt;1 yr</th>
<th>1–6 yrs</th>
<th>7–18 yrs</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOTAL VFC-ELIGIBLE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. CHDP/Medi-Cal Eligible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Uninsured</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. American Indian or Alaskan Native</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Underinsured (FQHCs</td>
<td>RHCs only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NON-VFC ELIGIBLE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL OF ALL CHILDREN (VFC-ELIGIBLE AND NON-VFC ELIGIBLE)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What data source was used to determine patient estimates?

- Billing info
- Usage Logs
- CAIR/Registry
- Patient Log
- Electronic Health Records
- Medi-Cal Claims Data
- Provider Encounter 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
- PCV13
- Varicella
- Meningococcal
- Rotavirus
- IPV
- Hep A
- Td
- DTaP
- Influenza
- Tdap
- Hib
- MMR
- HPV

## 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.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>National Provider ID (NPI)</th>
<th>Medical License Number</th>
<th>Title</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
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<tr>
<td>4</td>
<td></td>
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<tr>
<td>5</td>
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<tr>
<td>6</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8</td>
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<tr>
<td>9</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 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:

<table>
<thead>
<tr>
<th>Unit Location/ID</th>
<th>Use</th>
<th>Refrigerator Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>○ Primary</td>
<td>○ Under Counter</td>
</tr>
<tr>
<td></td>
<td>○ Day Use</td>
<td>○ Combination</td>
</tr>
<tr>
<td></td>
<td>○ Backup/Overflow</td>
<td>○ Stand alone</td>
</tr>
</tbody>
</table>

#### Refrigerator Storage Unit

<table>
<thead>
<tr>
<th>Brand, Model</th>
<th>Storage Capacity (in cubic feet)</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>○ Household</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Commercial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Pharmacy/Laboratory/Biologic</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thermometer Type</th>
<th>Thermometer Model</th>
<th>Thermometer Serial Number</th>
<th>Calibration Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Digital MIN/MAX Thermometer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Data Logger/Continuous Temperature Monitoring Device</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Freezer Storage Unit

<table>
<thead>
<tr>
<th>Unit Location/ID</th>
<th>Use</th>
<th>Freezer Type</th>
</tr>
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<tbody>
<tr>
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<td></td>
<td>○ Day Use</td>
<td>○ Combination</td>
</tr>
<tr>
<td></td>
<td>○ Backup/Overflow Use</td>
<td>○ Chest Freezer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Brand, Model</th>
<th>Storage Capacity (in cubic feet)</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
</tr>
<tr>
<td>○ Data Logger/Continuous Temperature Monitoring Device</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Backup Thermometer

<table>
<thead>
<tr>
<th>Thermometer Type</th>
<th>Thermometer Model</th>
<th>Thermometer Serial Number</th>
<th>Calibration Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Digital MIN/MAX Thermometer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Data Logger/Continuous Temperature Monitoring Device</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Other</td>
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<td></td>
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