



Vermont Immunization Program  
Provider Profile and Enrollment in the Vaccines for Children (VFC) and/or the Vaccines for  
Adults (VFA) Program

Please check one box:

- Vaccines for Children Program
- Vaccines for Adults Program
- Vaccines for Children & Vaccines for Adults Program

Physician-In-Charge: \_\_\_\_\_

State of Vermont Medical License Number: \_\_\_\_\_

Name of Practice: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Email Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Physical Street Address:

\_\_\_\_\_

Mailing Address:  Check here if mailing address is the same as above

\_\_\_\_\_

Days/ Hours Open for Delivery of Vaccines: \_\_\_\_\_

\_\_\_\_\_

Type of Facility:

- |  |  |
|--|--|
| <input type="checkbox"/> A. Public Health Department               | <input type="checkbox"/> D. Federally Qualified/ Rural Health Center |
| <input type="checkbox"/> B. Public Hospital                        | <input type="checkbox"/> E. Private Hospital                         |
| <input type="checkbox"/> C. Private Practice (Individual or Group) | <input type="checkbox"/> F. Other Facility _____                     |

**Profit**

**Non-profit**  If your organization is non-profit as defined by Section 501(c)(3) of the Internal Revenue Service Tax Code, please check this box.

*If unsure of your tax status please consult your auditor or business manager.*

\_\_\_\_\_

## Immunization Data:

**NOTE:** The following information is used to determine the amount of vaccine needed for your practice and **MUST** be based on actual data, not estimates.

**DATA SOURCE:** Vermont Department of Health Doses Administered Data from 2009

Part A. Based on the data source listed above, below is the projected number of children who will receive vaccinations at your health care facility by age group for a 12 month period beginning July 1, 2010.

<1 Year	1-6 Years	7-18 Years	Total Number of Children

For adult patients

≥ 19 Years	Total Number of Adults

If you only offer immunization services to adults do not fill out part B.

Part B. Take the number of children above and indicate the number of who are expected to be VFC eligible, by category and age group below.

\*\*\* Underinsured: Only a FQHC or RHC should complete the Underinsured row.

	< 1 Year	1 – 6 Years	7 – 18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
Amer. Indian/Alaskan Native				
*** Underinsured (Only FQHC/RHC)				
Total				

## Provider Agreement to Enroll in the Vaccines For Children (VFC) and/or Vaccine For Adults (VFA) Program

The Vermont Department of Health Immunization Program receives funding for vaccines from the Federal grant "Immunizations and VFC" grant H23CH1222529, CFDA # 93.268.

In order to participate in the Vermont Department of Health (VDH) Vaccines For Children (VFC) &/or the Vaccines for Adults (VFA) Program, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this provider office.

1. I will screen patients ( $\leq$  18 years of age) for VFC Program eligibility and document who qualifies under one or more of the following categories:
  - a) Is an American Indian or Alaskan Native
  - b) Is enrolled in Medicaid (or qualified through a State Medicaid waiver)
  - c) Has no health insurance
  - d) Has health insurance that does not pay for the vaccine (only applicable to FQHC or RHC)

And/or

I will screen patients (19 years of age and older) for the VFA program eligibility by ensuring that the patient is a Vermont resident.

2. I will maintain all records related to the VFC & VFA program for a minimum of three years and make these records available to public health officials including the Vermont Department of Health or the Department of Health and Human Services (DHHS) upon request.
3. I will permit visits to my facility by authorized representatives of the VDH Immunization Program to review compliance with VFC and/or VFA Program requirements including vaccine storage and record-keeping.
4. I will comply with and administer vaccines according to the appropriate immunization schedule, dosage, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP), and included in the VFC and/or VFA Program except if the following applies:
  - a) In my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate
  - OR
  - b) The particular requirement contradicts Vermont law pertaining to religious and other exemptions.
5. I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA). This includes reporting clinically significant adverse events to the Vaccine Adverse Events Reporting System (VAERS).
6. I will not impose a charge for the cost of the vaccine provided to my practice through federal and state funding.
7. I will not impose a charge for the administration of the vaccine to the non-Medicaid, VFC eligible child that is higher than the maximum fee of \$13.86 established by the federal government. I will accept reimbursement for immunization administration set by the state Medicaid agency. I will not deny administration of a federally purchased vaccine to a child because the child's parent/guardian/individual of record is unable to pay the administration fee.
8. I will comply with the following requirements for ordering, proper storage, handling and accountability of vaccine.
  - a) I will designate personnel to be responsible for vaccine.
  - b) Vaccine personnel will develop vaccine storage and handling plan for my practice site, or use the Vermont Department of Health template plan.

- c) My practice will have appropriate equipment that can store vaccine and maintain proper conditions. Two types of storage units are acceptable: 1. A refrigerator that has a separate freezer compartment with a separate exterior door or; 2. stand alone refrigerator and freezers.
  - d) My practice will use a certified, calibrated thermometer in the vaccine storage units. Refrigerator and freezer temperatures MUST be logged twice a day (once in the AM and once in the PM). Refrigerator temperatures are required to be (2° – 8° C) or (35° – 46° F) and freezer temperatures are required to be (5° F or colder) or (-15° C or colder). Any out of range temperatures MUST be reported to the Immunization Program immediately. Please call 1-800-464-4343 ext. 7638 or 1-802-863-7638.
  - e) My practice will follow proper vaccine storage practices (e.g. rotation of vaccine stock, correct vaccine placement in refrigerator unit).
  - f) I will report vaccine usage, waste, current inventory, and expiration dates on the Vaccine Accountability Sheets. I will notify the Vermont Department of Health Immunization Program if vaccine expires, wasted or is exposed to out-of-range temperatures.
  - g) I agree to operate in a manner intended to avoid fraud and abuse.
  - h) I understand that my responsibility for proper storage and handling of vaccine begins when delivery is accepted. I will check vaccine temperature monitors and take action if cold chain monitor was activated.
  - i) My practice site will correctly prepare and administer vaccines
  - j) My practice will conduct a monthly inventory to monitor vaccine use, and will order vaccine in accordance with vaccine need and federal and state guidance.
  - k) Vaccine security and equipment maintenance will be performed by my practice site.
  - l) I will cooperate with the VDH to recall patients if doses were mishandled or administered incorrectly.
    - If there is mishandled vaccine, the VDH Immunization Program will make every effort to work with the clinic in question to address the administration of mishandled vaccine, balancing clinic needs, cost to parents, providers and health plans, risk of illnesses or outbreaks, and overall affect on public health.
    - General recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP) recommendations that define and designate proper vaccine storage and handling will be followed. IF doses administered are of questionable potency, these doses should not be counted as valid and should be repeated.
    - The VDH may offer limited resources, as available, to assist with recalls and revaccination.
    - If a clinic declines to recall patients who received questionable doses, the VDH may request a list of affected patients and, in conjunction with the local health department, may conduct its own recall of these patients, in which case the clinic may be billed for the mishandled vaccine.
    - If a clinic declines to provide a list of affected patients, the VDH may issue a community notice alerting patients that they have received a potentially non-viable dose of vaccine at this clinic, and encourage these patients to contact the local health department to explore revaccination.
    - Recognizing the diversity of potential storage and handling issues that may arise, the VDH Immunization Program reserves the right to manage all cases of mishandled vaccine on a case-by-case basis, while adhering to the above guidelines.
  - m) I understand that failure to store and handle vaccines properly may result in a fine or financial liability to reimburse the VDH Immunization Program for mishandled/wasted doses.
9. I will renew enrollment annually.
10. I understand that the VDH Immunization Program may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons. If I terminate this agreement, I will properly return any unused vaccine purchased with federal or state funding.

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Signature of Physician-In-Charge

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Print Name of Physician-In-Charge

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Date

# Additional Providers within the Practice

Provider Profile and Enrollment (continued)

Please print or type the names and medical license numbers of all health care providers in your practice (attach copies of the Additional Providers within the Practice sheet if additional space is needed).

_____ Last Name, First, MI (Provider must have prescription writing privileges)	_____ Medical License Number	_____ Title (MD, DO, DN, NP, PA)
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This record is to be submitted to and kept on file at the Vermont Department of Health Immunization Program and must be updated annually. For questions call 1-800-464-4343 ext. 7638 or 802-863-7638.

VERMONT DEPARTMENT OF HEALTH  
IMMUNIZATION PROGRAM  
P.O. BOX 70  
108 CHERRY STREET  
BURLINGTON, VT 05402

# Provider Agreement and Guidelines for Varicella Vaccine

For VFC enrolling practices only

**ELIGIBILITY:** The Vermont Department of Health Immunization Program provides varicella vaccine for children ages 12 months through 18 years. Adult patients who need varicella vaccine can be vaccinated through the VDH District Offices if they present 1.) A prescription for varicella vaccine and 2.) A copy of a negative titer for varicella.

**STORAGE REQUIREMENTS:** If you wish to receive varicella vaccine you will have to complete this signed agreement showing that your practice meets the following guidelines for proper storage and handling.

- a) Merck & Company, Inc. the manufacturer of VARIVAX will pack and ship varicella vaccine with dry ice directly to the provider office after receiving an order from CDC, which is submitted by the Immunization Program.
- b) Varicella vaccine MUST be stored in a freezer, and MUST maintain temperatures at or below -15° C (+5 F).
- c) The freezer MUST have a separate door from the refrigerator, (e.g. regular household refrigerator). Dorm-style or larger refrigerator/freezer combinations where the freezer is within the refrigerator is NOT acceptable.
- d) Freezer temperatures must be recorded twice a day and any out of range temperatures MUST be reported to the Immunization Program immediately. Please call 1-800-464-4343 ext. 7638 or 1-802-863-7638.
- e) State-Supplied varicella vaccine cannot be moved or redistributed from the provider site that received it.

Practice Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_  
(Office Vaccine Manager)

Contact Telephone Number: \_\_\_\_\_

I agree to the additional conditions herein for the storage, handling and use of varicella vaccine.

\_\_\_\_\_  
Signature of Physician-In-Charge

\_\_\_\_\_  
Print Name of Physician-In-Charge

\_\_\_\_\_  
Date