

**Florida Vaccines for Children (VFC) Program
Provider Initial Enrollment Form
Provider Profile Section**

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VFC PIN # Assigned:

Please note: This document is very important. It provides necessary shipping information and helps determine the amount of vaccine the VFC Program will supply.

Physician/Group Practice/Other Entity:

Mailing Address: (If different from shipping address)

City:

Zip Code:

Delivery Instructions: Between the hours of 8 a.m. and 5 p.m., your local time, please write the **days of the week and times you may receive vaccine deliveries:**

Day of the Week	Open Time	Lunch Time	Closed Time
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Write the time your office is closed for business (for example: Friday 1:00 p.m. to 5:00 p.m.): _____

In a 12 months period, **estimate** the number of VFC children, by age and eligibility, who will be immunized at this location: (For example: 3 in the "< 1 year old" category, 4 in the "1-6 years old" category, and 2 in the "7-18 years old" yields 9 total). (Note: Do not count a child in more than one category.)

VFC Eligibility	<1 Year	1-6 Years	7-18 Years	Total
Enrolled in Medicaid				
Without Health Insurance				
American Indian/Alaskan Native				
Underinsured (has health insurance but it does not cover immunizations)				
Total				

Provider List Section

Print or type the names and medical license numbers of all health providers who may administer vaccines at this location.

Last Name, First, MI	Medical License	Title (MD, DO, NP, PA)	Specialty (Peds, Family Med, GP, Other [specify])

Signature: _____
(Medical Doctor, Doctor of Osteopathy, Nurse Practitioner, or Physician Assistant)

Date: _____

Mail or fax these forms to:

Florida Vaccines for Children (VFC) Program
4052 Bald Cypress Way, Bin A-11, Tallahassee, FL 32399-1700
Fax: (850) 245-4734
Website: <http://www.immunizeflorida.org/vfc/>
Email Address: FloridaVFC@doh.state.fl.us