

Florida Vaccines for Children (VFC) Program Provider Recertification Form			Page 1 of 2 VFC PIN # Assigned:												
			County:												
Name of Physician's Office, Practice, or Clinic			Date:												
Shipping Address: (Number and Street, no P.O. Boxes)			City: Zip Code:												
Contact Person:	Telephone Number:	Fax Number:	Email Address:												
Check the one provider category that best describes you: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Physician</td> <td><input type="checkbox"/> Community Health Center</td> <td><input type="checkbox"/> Physician Assistant</td> </tr> <tr> <td><input type="checkbox"/> Group Practice</td> <td><input type="checkbox"/> Federally Qualified Health Center</td> <td><input type="checkbox"/> County Public Health Unit</td> </tr> <tr> <td><input type="checkbox"/> HMO</td> <td><input type="checkbox"/> Rural Health Clinic</td> <td><input type="checkbox"/> Walk-In Clinic</td> </tr> <tr> <td><input type="checkbox"/> Hospital</td> <td><input type="checkbox"/> Nurse Practitioner</td> <td><input type="checkbox"/> Other (specify):</td> </tr> </table>				<input type="checkbox"/> Physician	<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Group Practice	<input type="checkbox"/> Federally Qualified Health Center	<input type="checkbox"/> County Public Health Unit	<input type="checkbox"/> HMO	<input type="checkbox"/> Rural Health Clinic	<input type="checkbox"/> Walk-In Clinic	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Physician	<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Physician Assistant													
<input type="checkbox"/> Group Practice	<input type="checkbox"/> Federally Qualified Health Center	<input type="checkbox"/> County Public Health Unit													
<input type="checkbox"/> HMO	<input type="checkbox"/> Rural Health Clinic	<input type="checkbox"/> Walk-In Clinic													
<input type="checkbox"/> Hospital	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Other (specify):													

Employer Identification Number (EIN) or Medical License Number: _____

In order to participate in the Vaccines for Children (VFC) Program and/or to receive other federally procured vaccine provided to me at no cost, I, on behalf of myself and all practitioners associated with this medical office, group practice, health maintenance organization, health department, community/rural clinic, or other entity of which I am the physician-in-chief or equivalent, agree to the following:

1. Screen patients at all immunization encounters for eligibility and administer VFC-purchased vaccine only to children who are 18 years of age or younger, and meet one or more of the following categories:
 - a. Federally vaccine-eligible
 - (1) American Indian or Alaskan Native
 - (2) Enrolled in Medicaid
 - (3) Has no health insurance
 - (4) Underinsured: Children who have commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (VFC- eligible for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount-- once that coverage amount is reached, these children are categorized as underinsured. Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
2. Comply with immunization schedule, dosage, and contraindications that are established by the ACIP and included in the VFC Program, unless:
 - a. In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate.
 - b. The particular requirements contradict state law, including those pertaining to religious and other exemptions.
3. Maintain all records related to the VFC Program for a minimum of three years and make these records available to public health officials including the state or Department of Health and Human Resources (DHHR) and Department of Health and Human Services (DHHS) upon request.
4. Immunize eligible children with VFC-supplied vaccine at no charge for the vaccine to the patient or parent.
5. Not charge a vaccine administration fee to the non-Medicaid VFC-eligible children that exceed the administration fee cap of \$16.06 per vaccine dose. For Medicaid VFC-eligible children, accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.
6. Not deny administration of a federally purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee. *Please Note: The term "established patient" applies only to private providers enrolled in the VFC Program. FQHCs/RHCs must administer VFC vaccine to any VFC-eligible children who presents for immunization services at their facilities.*
7. Distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Compensation Act (NCVIA) which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8. Comply with the requirements for ordering, vaccine accountability, and vaccine management. Agree to operate within the VFC Program in a manner intended to avoid fraud and abuse. I assume responsibility for the proper handling and storage of VFC-provided vaccine after delivery to my facility and understand that I may have to pay for vaccine wastage due to neglect.
9. The grantee or the provider may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If the provider chooses to terminate the agreement, he or she agrees to properly return any unused VFC vaccine.

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

Name (Print) _____

License Number: _____ or DEA Number: _____

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

Page 2 of 2
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	-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