

## Florida Vaccines for Children Program Provider Reenrollment Form

Instructions: The Provider Reenrollment Form is the provider's agreement to comply with all the conditions of the VFC Program. Providers must complete this form annually.

1. Complete this form. You may also submit this form electronically via our website at [http://www.immunizeflorida.org/vfc/provider\\_recertification\\_form.htm](http://www.immunizeflorida.org/vfc/provider_recertification_form.htm).
2. Fax or mail your application to:  
 Florida Vaccines for Children Program  
 4052 Bald Cypress Way, Bin A-11, Tallahassee, FL 32399-1700  
 Fax: (850) 245-4734
3. All providers must comply with the VFC Program Vaccine Storage Equipment Requirements. I agree to the following:
  - I have a certified, calibrated thermometer.
  - I have a stand-alone, two-door refrigerator/freezer or equivalent unit.
  - I will notify the VFC Program when the primary person responsible for vaccine management changes.

Provider Profile Section			
NAME OF PHYSICIAN'S OFFICE, PRACTICE, OR CLINIC		ASSIGNED VFC PIN	
Vaccine Delivery Information		Mailing Information	
VACCINE DELIVERY ADDRESS (Number/Street - No P.O. Boxes)		MAILING ADDRESS (if different from shipping information)	
CITY	ZIP CODE	CITY	ZIP CODE
TELEPHONE NUMBER		FAX NUMBER	
Primary Name of Person Responsible for vaccine: (required)		EMAIL ADDRESS	
Secondary Name of Person Responsible for vaccine: (required)		EMAIL ADDRESS	
<b>Check the one provider category that best describes you:</b>			
<input type="checkbox"/> Doctor's Clinic <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> County Health Department <input type="checkbox"/> FQHC <input type="checkbox"/> Birthing Hospital		<input type="checkbox"/> Indian Tribes <input type="checkbox"/> School Clinic <input type="checkbox"/> Community Health Center <input type="checkbox"/> Juvenile Correctional Center <input type="checkbox"/> Other (specify):	

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.
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. Enroll in the Florida State Health Online Tracking System (SHOTS), the statewide immunization registry, in order to place vaccine orders. Participation in Florida SHOTS will facilitate direct ordering of vaccine by VFC providers in the future. If you do not have a Florida SHOTS account, complete an enrollment form online at <https://www.flshots.com/flshots/enroll/applicantquestions.html>. If you do not know if you have a Florida SHOTS account, contact the Florida SHOTS help desk at 1 (877) 888-7468.
10. 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.

*All providers must comply with Vaccine Storage Equipment Requirement. Providers are required to have certified, calibrated thermometers, and stand-alone, two-door refrigerator/freezer units.*

Signature: \_\_\_\_\_  
 Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP), or Physician Assistant (PA)

Name (Print) \_\_\_\_\_ Date: \_\_\_\_\_

Medical License Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**Provider Profile Section**

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

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

**LUNCH TIME:** \_\_\_\_\_

**Please Note:** It is the provider's responsibility to notify the VFC Program in advance if the offices will be closed during the days and times which are normally open for business. You can reach a VFC representative at (800) 483-2543, option 6.

