Vaccines for Adults & Local Health Department 317 Programs
RECERTIFICATION WORKSHEET

CDPH | VFA | LHD 317

Use this worksheet to gather information needed ahead of time to complete the online VFA or LHD 317 Recertification Form on MyCAvax.cdph.ca.gov.

DO NOT SUBMIT THIS WORKSHEET TO THE VFA or LHD 317 PROGRAMS.

Step 1– Provider Location Information

Location Name		PIN	CAIR/IIS ID
Practice Information/Shipping Address (No P.O. Box)		City	ZIP
Shipping Address, Part 2		County	
Tax ID/Employee Identification Number (EIN)	National Provider Identifier (NPI)	Phone	Fax
MEDI-CAL Provider? ☐ Yes ☐ No	Is this a mobile facility, or does this facility have mobile units? ☐ Yes ☐ No		

DELIVERY: Check all days and times you may receive vaccine. If closed during lunch hour, please specify.

☐ **Monday** From: _____ To _____ (Closed for lunch from: _____ to _____)
☐ **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 _____)

Step 2 – Key Practice Staff

Role/ Responsibility	Name	Title (MD, DO, NP, PA, PharmD)	Specialty/Clinic Title	National Provider ID	Medical License #	Contact Information
Provider of Record			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____ EZIZ User ID:
Vaccine Coordinator			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____ EZIZ User ID:
Backup Vaccine Coordinator			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____ EZIZ User ID:
Provider of Record Designee			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____ EZIZ User ID:

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Optional Key Practice Staff

Role/ Responsibility	Name	Title (MD, DO, NP, PA, PharmD)	Specialty/Clinic Title	National Provider ID	Medical License #	Contact Information
Additional Vaccine Coordinator			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____ EZIZ User ID:
Organization Vaccine Coordinator			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____ EZIZ User ID:
Additional Staff Members *(Staff who will receive program communications)*			Specialty: _____ Clinic Title: _____			Direct Phone Number: _____ Email for program updates: _____ EZIZ User ID:

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Step 3 – Storage Units

Enter all units that will be used to store VFA or LHD 317 vaccines and indicate at least one unit as the primary storage unit for vaccines.

Existing storage units from other programs are available to view and add to VFA or LHD 317 if storing in the same unit. Brand new units need to be added by completing the information below in myCAvax.

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

Refrigerator Type: ☐ Compact ☐ Combination ☐ Stand-Alone ☐ Auto-Dispensing Doorless	Unit Location/ID:	Brand, Model:
Unit Priority: ☐ Primary ☐ Backup/Overflow ☐ Mobile Unit ☐ No longer in use	Unit Grade: ☐ Household ☐ Commercial ☐ Purpose-Built (Pharmacy/Lab Grade)	Vaccines Stored: ☐ SGF ☐ VFA ☐ VFC ☐ BAP ☐ 317 ☐ Outbreak
Thermometer Type: ☐ Data Logger ☐ Networked continuous temperature monitoring system		Storage Capacity (in cubic feet):
Thermometer Model:	Thermometer Serial Number:	Calibration Expiration Date:

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

Freezer Type: ☐ Upright ☐ Combination ☐ Ultra-Cold ☐ Chest ☐ Auto-Dispensing Doorless	Unit Location/ID:	Brand, Model:
Unit Priority: ☐ Primary ☐ Backup/Overflow ☐ No Longer in Use ☐ Mobile Unit	Unit Grade: ☐ Household ☐ Commercial ☐ Purpose-Built (Pharmacy/Lab Grade)	Vaccines Stored: ☐ SGF ☐ VFA ☐ VFC ☐ BAP ☐ 317 ☐ Outbreak
Thermometer Type: ☐ Data Logger ☐ Networked continuous temperature monitoring system		Storage Capacity (in cubic feet):
Thermometer Model:	Thermometer Serial Number:	Calibration Expiration Date:

Your location must have a backup thermometer to continue recertification, please indicate information for your **BACKUP THERMOMETER** below:

Thermometer Type: ☐ Data Logger ☐ Networked continuous temperature monitoring system		Intention for Use: ☐ Refrigerator ☐ Freezer ☐ ULT ☐ Transport
Thermometer Model:	Thermometer Serial Number:	Calibration Expiration Date:

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Step 4–Provider Population

Estimated number of adults 19 years of age and older who will receive immunizations at your location during the upcoming 12-month period.

Eligibility	19-26	27-49	50-64	≥65	Total
Uninsured VFA/LHD 317 eligible patients					
Underinsured VFA/LHD 317 eligible patients					
Privately insured non-VFA/LHD 317 patients					

What data source did you use to confirm/modify your patient population? _____

Step 5–Health Care Providers with Prescription-Writing Privileges

You must have at least one medical staff listed. Medical staff are healthcare providers with prescription-writing privileges and all licenses must be verified. Health care provider medical licenses will be validated electronically. Please make sure you enter the name exactly as it appears on the medical license. Do NOT include middle name, middle initial, or title (e.g. MD, DO, etc.). You can verify that you have the correct license number from the California Department of Consumer Affairs.

	First Name	Last Name	Email	NPI#	Medical License Number	Title (MD, DO, PA, etc.)	Specialty	Clinic Title (Clinical Manager, IZ Coordinator, etc.)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

SUPPLEMENTAL PAGE FOR ADDITIONAL VACCINE STORAGE UNIT & TEMPERATURE MONITORING EQUIPMENT INFORMATION

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If you have additional vaccine storage units and/or thermometers, fill in the information below.

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

Refrigerator Type: ☐ Compact ☐ Combination ☐ Stand-Alone ☐ Auto-Dispensing Doorless	Unit Location/ID:	Brand, Model:
Unit Priority: ☐ Primary ☐ Backup/Overflow ☐ Mobile Unit ☐ No longer in use	**Unit Grade:** ☐ Household ☐ Commercial ☐ Purpose-Built (Pharmacy/Lab Grade)	**Vaccines Stored:** ☐ SGF ☐ VFA ☐ VFC ☐ BAP ☐ 317 ☐ Outbreak
Thermometer Type: ☐ Data Logger ☐ Networked continuous temperature monitoring system		**Storage Capacity (in cubic feet):**
Thermometer Model:	**Thermometer Serial Number:**	**Calibration Expiration Date:**

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

Freezer Type: ☐ Upright ☐ Combination ☐ Ultra-Cold ☐ Chest ☐ Auto-Dispensing Doorless	Unit Location/ID:	Brand, Model:
Unit Priority: ☐ Primary ☐ Backup/Overflow ☐ Day Use ☐ Mobile Unit	**Unit Grade:** ☐ Household ☐ Commercial ☐ Purpose-Built (Pharmacy/Lab Grade)	**Vaccines Stored:** ☐ SGF ☐ VFA ☐ VFC ☐ BAP ☐ 317 ☐ Outbreak
Thermometer Type: ☐ Data Logger ☐ Networked continuous temperature monitoring system		**Storage Capacity (in cubic feet):**
Thermometer Model:	**Thermometer Serial Number:**	**Calibration Expiration Date:**

Your location must have a backup thermometer to continue recertification, please indicate information for your **BACKUP THERMOMETER** below:

Thermometer Type: ☐ Data Logger ☐ Networked continuous temperature monitoring system		Intention for Use: ☐ Refrigerator ☐ Freezer ☐ ULT ☐ Transport
Thermometer Model:	**Thermometer Serial Number:**	**Calibration Expiration Date:**