VACCINES FOR CHILDREN (VFC) PROGRAM

PARTICIPATION WITHDRAWAL REQUEST FORM

Complete and fax to the VFC Program at (877) 329-9832 **at least 30 days before withdrawing program participation.**

INSTRUCTIONS: Providers are required to notify the VFC Program at least 30 days before the practice intends to terminate its VFC Provider Agreement and withdraw participation from the California VFC Program. Note that a waiting period of up to 12 months may apply for re-enrollment requests. Until your withdrawal request is approved and finalized

- Store vaccines and document temperatures according to VFC Program requirements.
- The practice is responsible for all VFC-supplied vaccines. Failure to account for doses or protect vaccine viability may result in a negligent loss leading to vaccine replacement.

A VFC Program Field Representative will contact you regarding transferring or retrieving viable VFC-supplied vaccines.

Practice Information

Practice Name			PIN
Address	City	ZIP	County
E-mail	Phone		Fax

Withdrawal Information

Provider of Record Name (print):	Effective Date for Withdrawal:
Provider of Record (signature):	Today's Date:
Do you have remaining VFC-supplied vaccines on hand? **Y or N** If Yes, complete "Remaining Vaccine Inventory Information."	Have you notified your VFC representative about your request and on-hand VFC inventory? **Y or N**

Please indicate the reason for withdrawing your participation from the VFC Program:

Practice:

[ ] Closing office
[ ] Merged with another facility
[ ] Change in practice ownership
[ ] No longer seeing VFC-eligible children
[ ] Serves too few VFC-eligible children
[ ] No longer offering immunization services
[ ] No longer enrolled in Medi-Cal

Program Requirements:

[ ] VFC Program requirements are too burdensome
Specify requirement(s): _____
[ ] VFC Program participation too time consuming/costly
Specify requirement(s): _____
[ ] Cannot resolve VFC compliance issues
[ ] Other (specify): _____

Comments

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Remaining Vaccine Inventory Information

INSTRUCTIONS: Complete this section if your practice has VFC-supplied vaccines on hand.

Vaccines Specify type, such as DTaP.	**Number of VFC Doses Used Since Last Order.** Enter 0 if None.	**Vaccine Inventory**			**Disposition**
		Number of VFC Doses On Hand	**Manufacturer**	**Lot Number**	**Transaction Code** (See below)

Note: You are reponsible for all VFC-supplied vaccines you have received. Therefore, you must account for any missing vaccines by correcting vaccine usage or replacing the missing VFC doses.

TRANSACTION CODES: Enter one of these codes in the column above. Provide additional information as necessary.

Code	Meaning	Additional Information	Notes
1	Request Viable Vaccines be Returned to VFC Program	Name	VFC Field Representative will pick up viable VFC-supplied vaccines
2	Request Viable Vaccines be Transferred to Another VFC Provider	PIN Phone	Prior approval required
3	Spoiled Vaccines Returned to VFC Program	Return spoiled or expired vaccines to: **McKesson Specialty Distribution Center** **3400 Fraser Street** **Aurora, CO 80011**	
4	Expired Vaccines Returned to VFC Program		

INSTRUCTIONS: Fax this completed form to the VFC Program 30 days before the date of your request to withdraw from the VFC Program. A VFC Field Representative will contact you regarding the disposition of VFC-supplied vaccines.

Fax form to 877-FAXX-VFC (877-329-9832)