**VACCINES FOR CHILDREN (VFC) PROGRAM**

# 2017 VFC RECERTIFICATION WORKSHEET

Use this worksheet to gather information needed ahead of time to complete the online VFC Recertification Form on MyVFCvaccines.org.

**DO NOT SUBMIT THIS WORKSHEET TO THE VFC PROGRAM.**

## Practice Information/Shipping

| | | | |
|---|---|---|---|
| Practice Name | | Contact Person | PIN |
| Practice Information/Shipping Address (No P.O. Box) | | County | Registry ID |
| Shipping Address, Part 2 | | City | ZIP |
| Employer Identification Number (EIN) | National Provider Identifier (NPI) | Phone | Fax |
| CHDP Provider? ◯ Yes ◯ No | MEDI-CAL Provider? ◯ Yes ◯ No | Would you like to be on the VFC online locator? ◯ Yes ◯ No | |

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

| | | | | | |
|---|---|---|---|---|---|
| **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: | ) |

## 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: _____ |
| Vaccine Coordinator | | | Specialty: _____ Clinic Title: _____ | | | Direct Phone Number: _____ Email: _____ |
| Backup Vaccine Coordinator | | | Specialty: _____ Clinic Title: _____ | | | Direct Phone Number: _____ Email: _____ |
| Provider of Record Designee | | | Specialty: _____ Clinic Title: _____ | | | Direct Phone Number: _____ Email: _____ |

# 2017 VFC RECERTIFICATION WORKSHEET

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## Vaccine Storage Units & Temperature Monitoring Equipment Information

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

| | | | |
|---|---|---|---|
| **Unit Location/ID** | **Use** ◯ Primary ◯ Day Use ◯ Backup/Overflow | **Refrigerator Type** ◯ Under Counter ◯ Combination ◯ Stand-alone | |
| **Brand, Model** | **Storage Capacity (in cubic feet)** | **Grade** ◯ Household ◯ Commercial ◯ Pharmacy/Laboratory/Biologic | |

**Thermometer Type**

◯ Digital MIN/MAX Thermometer ◯ Data Logger/Continuous Temperature Monitoring Device ◯ Other_____

| | | |
|---|---|---|
| **Thermometer Model** | **Thermometer Serial Number** | **Calibration Expiration Date** |

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

| | | | |
|---|---|---|---|
| **Unit Location/ID** | **Use** ◯ Primary ◯ Day Use ◯ Backup/Overflow Use | **Freezer Type** ◯ Upright Freezer ◯ Combination ◯ Chest Freezer | |
| **Brand, Model** | **Storage Capacity (in cubic feet)** | **Grade** ◯ Household ◯ Commercial ◯ Pharmacy/Laboratory/Biologic | |

**Thermometer Type**

◯ Digital MIN/MAX Thermometer ◯ Data Logger/Continuous Temperature Monitoring Device ◯ Other_____

| | | |
|---|---|---|
| **Thermometer Model** | **Thermometer Serial Number** | **Calibration Expiration Date** |

Indicate information for your **BACKUP THERMOMETER** below:

**Thermometer Type**

◯ Digital MIN/MAX Thermometer ◯ Data Logger/Continuous Temperature Monitoring Device ◯ Other_____

| | | |
|---|---|---|
| **Thermometer Model** | **Thermometer Serial Number** | **Calibration Expiration Date** |

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## Patient Population

| Estimated number of children who will receive immunizations at your practice or clinic for a 12-month period, by category: | Ages (Note: Do not count a child in more than one category.) | | | TOTAL |
|---|---|---|---|---|
| | <1 yr | 1–6 yrs | 7–18 yrs | |
| TOTAL VFC-ELIGIBLE | | | | |
| a. CHDP/Medi-Cal Eligible | | | | |
| b. Uninsured | | | | |
| c. American Indian or Alaskan Native | | | | |
| d. Underinsured (FQHCs \| RHCs only) | | | | |
| NON-VFC ELIGIBLE | | | | |
| TOTAL OF ALL CHILDREN (VFC-ELIGIBLE AND NON-VFC ELIGIBLE) | | | | |

What data source was used to determine patient estimates?

- ○ Billing info
- ○ Usage Logs
- ○ Electronic Health Records
- ○ Provider Encounter Data
- ○ CAIR/Registry
- ○ Patient Log
- ○ Medi-Cal Claims Data
- ○ Other _____

## ACIP Recommended Vaccines Offered

Indicate all age-appropriate ACIP-recommended vaccines your practice will offer:

☐ *I certify that my practice will order and provide all age-appropriate ACIP-recommended vaccines to my VFC-eligible patient populations. Below are the age-appropriate ACIP-recommended vaccines that I will provide based on my patient estimates.*

- ○ Hep B
- ○ Rotavirus
- ○ DTaP
- ○ Hib
- ○ PCV13
- ○ IPV
- ○ Influenza
- ○ MMR
- ○ Varicella
- ○ Hep A
- ○ Tdap
- ○ HPV
- ○ Meningococcal
- ○ Td

## List of Health-Care Providers with Prescription-Writing Privileges

***Instructions:*** *Use this form to list all health-care providers at your facility with prescription-writing privileges who will administer VFC supplied vaccines. Note: It is not necessary to include the names of all staff who may administer VFC vaccine, but rather only those who possess a medical license or are authorized to write prescriptions.*

| | Last Name | First Name | National Provider ID (NPI) | Medical License Number | Title | Specialty |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

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

**DO NOT SUBMIT THIS WORKSHEET TO THE VFC PROGRAM.**

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

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

| | | | |
|---|---|---|---|
| **Unit Location/ID** | **Use** ◯ Primary ◯ Day Use ◯ Backup/Overflow | **Refrigerator Type** ◯ Under Counter ◯ Combination ◯ Stand alone | |
| **Brand, Model** | **Storage Capacity (in cubic feet)** | **Grade** ◯ Household ◯ Commercial ◯ Pharmacy/Laboratory/Biologic | |

**Thermometer Type**

◯ Digital MIN/MAX Thermometer ◯ Data Logger/ Continuous Temperature Monitoring Device ◯ Other_____

| | | |
|---|---|---|
| **Thermometer Model** | **Thermometer Serial Number** | **Calibration Expiration Date** |

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

| | | | |
|---|---|---|---|
| **Unit Location/ID** | **Use** ◯ Primary ◯ Day Use ◯ Backup/Overflow Use | **Freezer Type** ◯ Upright Freezer ◯ Combination ◯ Chest Freezer | |
| **Brand, Model** | **Storage Capacity (in cubic feet)** | **Grade** ◯ Household ◯ Commercial ◯ Pharmacy/Laboratory/Biologic | |

**Thermometer Type**

◯ Digital MIN/MAX Thermometer ◯ Data Logger/ Continuous Temperature Monitoring Device ◯ Other_____

| | | |
|---|---|---|
| **Thermometer Model** | **Thermometer Serial Number** | **Calibration Expiration Date** |

Indicate information for your **BACKUP THERMOMETER** below:

**Thermometer Type**

◯ Digital MIN/MAX Thermometer ◯ Data Logger/ Continuous Temperature Monitoring Device ◯ Other_____

| | | |
|---|---|---|
| **Thermometer Model** | **Thermometer Serial Number** | **Calibration Expiration Date** |