Provider Enrollment
Vaccines for Children Program

PIN #_____

Physician: _____
Last First MI

Clinic: _____

Address: _____
Street City State Zip Code

Telephone: ( ) _____ **Fax** ( ) _____

1. Contact Name: _____
Last First

2. Contact Name: _____
Last First

Employer Identification Number: _____ Medical License Number: _____ Medicaid Provider Number: _____

Is your practice/clinic a: Federally Qualified Health Center (FQHC)? ☐ Yes ☐ No
Rural Health Clinic (RHC)? ☐ Yes ☐ No

To participate in the Vaccines for Children (VFC) program and receive federally procured vaccine provided to my facility at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this medical office, group practice, managed care organization, community/migrant/rural clinic, health department, or other health delivery facility of which I am the physician-in-chief or equivalent:

1. I will screen patients and administer VFC Program purchased vaccine only to a child (≤ 18 years of age) who qualifies under one or more of the following categories: a) is an American Indian or Alaskan Native; b) is on Medicaid (or qualified through a state Medicaid waiver); c) has no health insurance; or d) has health insurance that does not pay for the vaccine (only applicable to FQHC or RHC).

2. I will administer VFC vaccines only to children in eligible age cohorts for each vaccine, as set by the Advisory Committee on Immunization Practices (ACIP) in VFC resolutions.

3. I will maintain parent/guardian responses on the Patient Eligibility Screening Record form for a period of 3 years, unless my State requires a longer archival period. Release of such records will be bound by the privacy protection of the federal Medicaid law.

4. If requested, I will make such records available to the State or the Department of Health and Human Services (DHHS).

5. I will comply with the appropriate immunization schedule, dosage, and contraindications, that are established by the ACIP, unless a) in my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or b) the particular requirement contradicts the law in my State pertaining to religious and other exemptions. *

6. I will distribute written vaccine information and maintain records in accordance with the National Childhood Vaccine Injury Act.

7. I will not impose a charge for the cost of the vaccine.

8. I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the State ($14.49).

9. I will not deny administration of a federally procured vaccine to a child because the child's parent/guardian/individual of record is unable to pay the administration fee ($14.49).†

10. I will comply with the State's requirements for ordering vaccine, and the other requirements outlined on the attached forms.†

11. The State may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons.†

* Note: The ACIP Schedule is compatible with the AAP recommendations.

† If a provider receives vaccine purchased under a federal contract, but is not enrolled in the VFC program, the provider is only required to agree to these conditions.

_____ _____

Provider of Record (Physicians Signature) Date

Please print or type the names and medical license numbers of the other health providers who may administer vaccine (attach copies of the *Additional Providers within the Practice* sheet if additional space is needed). It is not necessary to include the names of all staff that may administer vaccine, but rather only those who possess a medical license or are authorized to write prescriptions.

Last Name, First, MI	Medical License No. Medicaid Provider No.	Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	Specialty (Peds, Family Med, GP, Other (specify)
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This record is to be submitted to and kept on file at the State department of health or public health agency, and must be updated in accordance with State policy.

For State Use Only (enter date in only one box):

Date certified for VFC: _____/_____/_____	Date certified for vaccine purchased under a federal contract, excluding VFC: _____/_____/_____
Date certified for VFC and other vaccine purchased under a federal contract: _____/_____/_____	

Provider Enrollment (continued)
Additional Providers within the Practice

Clinic Name: ____

Last Name, First, MI	Medical License No. Medicaid Provider No.	Title (MD, DO, ND, NP, PA) (Provider must have prescription writing privileges)	Specialty Peds, Family Med, GP, Other (specify)
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