VACCINES FOR CHILDREN (VFC) PROGRAM PROVIDER ENROLLMENT FORM–PRIVATE SECTOR

		PIN (6 digit)	
		COUNTY	
NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.		DATE	
ADDRESS *(Number and Street)*		CITY	ZIP CODE
CONTACT PERSON	MEDI-CAL/CHDP PROVIDER NUMBER	TELEPHONE ( )	FAX ( )
EMPLOYER IDENTIFICATION NUMBER	MEDICAL LICENSE NUMBER	EMAIL ADDRESS	

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 who is 18 years of age or younger who qualifies under one or more of the following categories:
   a. Is an American Indian or Alaskan Native;
   b. Is eligible for California's Child Health and Disability Prevention (CHDP) Program or Medi-Cal Program; or
   c. Has no health insurance.

   Note: Children with private health insurance and Healthy Family subscribers are not eligible for VFC vaccines.
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.

   Note: The ACIP schedule is compatible with the AAP recommendations.
3. I will maintain a record of each VFC-enrolled child's required information on VFC eligibility screening for a period of three (3) years. 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 permit visits to my facility by authorized representatives of the State or DHHS to review my compliance with VFC Program requirements including vaccine storage and record-keeping.
6. I will comply with the appropriate immunization schedule, dosage, and contraindications, that are established by the ACIP, unless:
   a. In my medical judgement, 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.

   Note:The ACIP schedule is compatible with the AAP recommendations.
7. I will distribute written vaccine information (e.g. Vaccine Information Statements [VISs]) and maintain records in accordance with the National Childhood Vaccine Injury Act.
8. I will not impose a charge for the cost of the vaccine.
9. I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the State. (The current maximum for the State of California is $17.55 per dose administered.)
10. I will not deny administration of a federally procured vaccine to a child because the child's parent or guardian or individual of record is unable to pay the administration fee.
11. I will comply with the State's requirements for ordering vaccine as outlined on VFC order forms, etc. (e.g., reporting via the order forms my previous VFC vaccine usage and my current inventory of VFC vaccine, ordering vaccine no more than once every two months-no more than six times per year, etc.)
12. I will be financially responsible for the replacement cost of any VFC-provided vaccines that I receive for which I cannot account or that spoil or expire because of negligence.
13. **I will use the VFC provided Fahrenheit (F°) Temperature Log and retain the "Temp Log" (IMM-682) record each month for a period of six (6) months.**
14. **I understand the State may terminate this agreement at any time for failure to comply with these requirements or without cause.**

    Note: I understand that if this agreement is terminated, I must return to the VFC Program all unused (viable and non-viable) VFC vaccine. I also will comply with the VFC Program's procedures for return of the vaccine.

PROVIDER OF RECORD	DATE

To be enrolled in and receive vaccines through the VFC Program (or to receive other federally procured vaccines), you must submit the white copy (original) of this form **with an ORIGINAL signature** to the following address. (Please retain the yellow copy for your records.) **FAXED COPIES OF THIS FORM WILL NOT BE ACCEPTED.**

Mail original copy to: VFC Program, State of California, Department of Health Services, Immunization Branch
2151 Berkeley Way, Rm. 712, Berkeley, CA 94704