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

PIN (6 digit)

COUNTY

THIS IS NOT A VACCINE ORDER FORM. *However, this form will help the State determine the amount of vaccine it will supply to participants in the VFC Program. The State also may use the information to compare the estimated needs of providers for vaccine with actual vaccine orders submitted.*

It is a federal requirement that each enrolled site to which VFC Program vaccines will be delivered must complete and submit this form with a VFC Program Profile-Supplemental Form (DHS 8499S) to the address below at least once a year to receive VFC-supplied vaccine. Each enrolled site also must submit a Provider Profile Form and Profile-Supplemental Form whenever (1) the estimated of eligible children to be served changes; (2) the status of the facility changes (e.g., a private provider becomes an agent of a federally qualified health center, etc.), or the persons with prescription-writing privileges changes. This form may be completed by one provider or the entire practice.

Please Print or Type. **Date:**

NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.

IF THIS OFFICE, CLINIC, ETC., IS PART OF A LARGER CORPORATE ENTITY OR DEPARTMENT, THE NAME OF THAT ENTITY IS:

STATE USE ONLY
Parent PIN: _____

EMPLOYER IDENTIFICATION NUMBER	MEDICAL LICENSE NUMBER	CHDP PROVIDER:	MEDI-CAL PROVIDER:
		❒ No ❒ Yes _____ Provider #	❒ No ❒ Yes _____ Provider #, If different from CHDP

TYPE OF FACILITY (Please Check The One Box That Represents the Bulk of Your Practice)

❒ Private Practice ❒ Private Hospital ❒ Other Private Sector *(Specify)* _____

PLEASE INDICATE IF ANY OF THE FOLLOWING INFORMATION HAS CHANGED.

❒ Vaccine Delivery Information ❒ Mailing Information ❒ Telephone Number ❒ Fax Number ❒ Email Address ❒ Times and Days for Delivery

Vaccine Delivery Information	**Mailing Information** *(If different from shipping information)*
CONTACT PERSON:	CONTACT PERSON:
VACCINE DELIVERY ADDRESS (Number/Street–No P.O. Boxes):	MAILING ADDRESS:
CITY: ZIP:	CITY: ZIP:

TELEPHONE NUMBER:	FAX NUMBER:	EMAIL ADRESS:
( )	( )	

DAYS AND TIMES FOR DELIVERY (**Specify ALL days and times during which you may receive vaccine deliveries**)

❒ Tues (Times: _____) ❒ Wed (Times: _____) ❒ Thurs (Times: _____) ❒ Fri (Times: _____)

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	1–6	7–18	
1. CHDP/Medi-Cal Eligible				
2. Without Private Insurance				
3. American Indian or Alaskan Native				
SUBTOTAL (1+2+3)				
4. Not Eligible for VFC Program Vaccine (Include children with health insurance and Healthy Families Program subscribers)				
TOTAL (1+2+3+4)				

**Choose only one category for each child. If the child meets two or more of the eligibility qualifications, choose the first one that applies.*

TYPE OF DATA USED FOR ESTIMATES

❒ Doses Administered Reports ❒ CHDP/Medi-Cal Claim Data ❒ Other *(Specify)* _____

Please send the white copy (original) to this address: and retain the yellow copy for your records.

Vaccines for Children (VFC) Program
California Department of Health Services
Immunization Branch
2151 Berkeley Way, Room 712
Berkeley, CA 94704
Toll-free Telephone: 877-2Get-VFC (877-243-8832)
Toll-free Fax: 877-FAXX-VFC (877-329-9832)