VACCINES FOR CHILDREN (VFC) PROGRAM PROVIDER PROFILE FORM—SUPPLEMENTAL

PIN (6 digit)	
COUNTY	
NAME OF PHYSICIAN'S OFFICE, PRACTICE, CLINIC, ETC.	DATE
ADDRESS *(Number and Street)*	CITY / ZIP CODE
CONTACT PERSON / EMAIL ADDRESS	TELEPHONE ( ) / FAX ( )

LAST NAME, FIRST, MI	MEDICAID PROVIDER NUMBER (i.e., CHDP or Medi-Cal number)	MEDICAL LICENSE NUMBER	TITLE (e.g., MD, DO, NP, PA– Provider must have prescription writing privileges)	SPECIALITY (e.g., Peds, Family Med, GP, Other [Specify])
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Instructions: You must use this form to list all health care providers at your facility with prescription writing privileges who will administer VFC Program-provided vaccines. (You may use additional copies of this form to list additional providers.) Submit this form with the VFC Provider Profile Form.

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.