

Provider Profile and Enrollment Form

Complete this form for each of your clinics/sites where vaccines are given.

A. Facility Name: _____

Contact Name(s): _____

First MI Last Title

Mailing Address: _____

Street Address and/or P.O. Box Number

City State Zip Code

**Vaccine Delivery
and Storage Address:** _____

Street Address (NO P.O. BOXES PLEASE)

City State Zip Code

Email Address: _____

Phone Number: () _____ **FAX Number:** () _____

Days/Times which you can receive vaccine deliveries (Indicate Days with "X"):

Monday _____ Times: _____

Tuesday _____ Times: _____

Wednesday _____ Times: _____

Thursday _____ Times: _____

Friday _____ Times: _____

B. Type of Facility: (✓ one only)

- | | |
|--|--|
| <input type="checkbox"/> Public Health Department (10) | <input type="checkbox"/> Public Hospital (12) |
| <input type="checkbox"/> Federally Qualified Health Center or Rural Health Center (15) | <input type="checkbox"/> Private Hospital (22) |
| <input type="checkbox"/> Physician's Solo Practice (20) | <input type="checkbox"/> Other Public (16) |
| <input type="checkbox"/> Physician's Group Practice (20) | <input type="checkbox"/> Other Private (24) |

C. Please estimate the number of children to be immunized at your practice/clinic for a 12-month period:

<u><1 Year</u>	<u>1-6 Years</u>	<u>7-18 Years</u>	<u>Total</u>
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D. Of the total number for each age group entered above, how many children are expected to be VFC eligible, by category?

	<u><1 Year</u>	<u>1-6 Years</u>	<u>7-18 Years</u>	<u>Total</u>
Enrolled in Medicaid	_____	_____	_____	_____
No Health Insurance	_____	_____	_____	_____
Underinsured (Health insurance does not cover vaccines)	_____	_____	_____	_____
American Indian/ Alaska Native	_____	_____	_____	_____
PeachCare for Kids- Enrolled	_____	_____	_____	_____

E. Varicella Information

What type of storage units does your facility have?

Refrigerator Type: (✓ one): Household Stand-Alone Commercial

Freezer Type: (✓ one): Household Stand-Alone Commercial None

Will your freezer maintain varicella vaccine at +5° F (-15° C) or colder? Yes _____ No _____

F. Practice Specialty:

- | | |
|--|---|
| <input type="checkbox"/> Pediatrics (Ped) | <input type="checkbox"/> Family Practice (FP) |
| <input type="checkbox"/> General Practice (GP) | <input type="checkbox"/> Internal Medicine (IM) |
| <input type="checkbox"/> Hospital (HOSP) | <input type="checkbox"/> Multi-Specialty (Mult) |
| <input type="checkbox"/> YDC | <input type="checkbox"/> Other |