



VFC PHYSICIAN PROFILE FORM

PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH
DIVISION OF DISEASE CONTROL / VACCINES FOR CHILDREN PROGRAM
500 S. BROAD ST., PHILADELPHIA, PA 19146
Phone: 215-685-6748 / Fax: 215-238-6948

FACILITY NAME:	VFC PIN #:
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All physicians (MD, DO) of a practice who see VFC-eligible patients must sign this form. If a provider is a nurse-practicing program, all nurses or Physician assistants (CRNP, RN, NP, PA) must complete and sign this form. ***This form must be updated whenever physicians join or leave the practice.***

I, the undersigned, do agree to all provisions stipulated on the VFC Provider Enrollment form for participation in the Philadelphia Vaccines for Children (VFC) Program: (PLEASE PRINT OR TYPE)

	Last Name	First Name	Title (MD, DO, NP, RN, LVN)	Pennsylvania Physician License Number	Medical Assistance Number OR National Provider Identification Number (Circle # listed)	Physician Signature
1					MA NPI	
2					MA NPI	
3					MA NPI	
4					MA NPI	
5					MA NPI	
6					MA NPI	
7					MA NPI	
8					MA NPI	
9					MA NPI	
10					MA NPI	