

Seasonal Influenza

2016-17 Registration Form



Department of
Public Health
CITY OF PHILADELPHIA
LIFE • LIBERTY • AND YOU™

Community-based Flu Vaccination Campaign (19-64 years, uninsured)

Registration Due: September 8, 2016 (all forms must be submitted by this date)

Health Department Contact: Nichole Dantzler

Phone Number: 215-685-6837

Agreement to participate in the 2016-17 flu season Campaign, please read the following and sign below:

1. I understand that flu vaccine provided by the Community-Based Influenza Vaccine Campaign (CFC) program at the Health Department this season is intended for patients who identify as not having health insurance. **Flu vaccine from the Health Department is not for the insured population.**
2. I will screen each patient for their age and health insurance status, and then document the screening on the Vaccine Administration Record (VAR form). **If patient is insured, I will not vaccinate them.**
3. I understand that anyone who presents at a clinic (as a walk-in, for example) is eligible to receive this clinic's vaccine as long as they identify as being uninsured, 19 through 64 years old, or 65 and older but not eligible for Medicare even if they are new to this community or clinic.
4. I understand that the Community-Based Influenza Vaccination Campaign at the Health Department provides vaccine and related supplies, and that providers may not charge or bill for Health Department vaccine or the services to vaccinate campaign participants.
5. I will supply a licensed and qualified clinician to administer vaccine to this population (the Health Department does not have nurses or staff available to serve at clinics; It is my responsibility as the individual coordinating CFC clinic(s) to supply a licensed person to administer flu vaccine doses at my clinic(s)).
6. I agree to return all vaccine and Vaccine Administration Records (VAR form) to the Health Department as instructed.
7. **I understand that I am responsible for proper storage and handling of this federally procured vaccine.**
8. I understand that only clinics that have been pre-approved and confirmed will be authorized by the Community-Based Influenza Vaccination Campaign and the Health Department.
9. Under **no** circumstances will I vaccinate anyone under 19 years of age with CFC vaccine.
10. I understand that if I do not follow requirements listed here, the agreement will be terminated with the Health Department.

Print Name	VFC/VFAAR PIN (if applicable)
Signature	Date

Fax to 215-238-6948 or scan and email to Nichole.Dantzler@phila.gov

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Clinic Population

Community-Based Influenza Vaccination Campaign (CFC) vaccine can only be administered to adults 19 through 64 years who identify as not having health insurance. Insured adults and adults age 65 and older eligible for Medicare cannot be administered PDPH flu vaccine through the CFC program. Patient screening must be documented.

If your planned clinic meets this Campaign's eligibility criteria, we will contact you to participate as a clinical partner in the Philadelphia Department of Public Health's 2016-17 Community-Based Influenza Vaccination Campaign. So that we may coordinate the scheduling process as efficiently as possible, and communicate with you effectively throughout the campaign, please **complete and return this form no later than Thursday, September 8, 2016**. Please complete the following pages of information.

Providers may schedule clinics directly with community sites, or choose to have their clinics scheduled by the Community-Based Influenza Vaccine Campaign program at the Health Department. Providers who schedule their own clinics must submit and confirm their schedule with the Community-Based Influenza Vaccine Campaign prior to the date of the clinic.

Are you a new provider for the 2016-17 flu season? Yes No

Provider Information	
Your First Name	Your Last Name
Work Phone Number	Work Fax Number
Email Address	Cell Phone Number

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Clinic Scheduling (photocopy this page if you need more space for clinic information)

Facility Information			
Facility Name		Facility Type	Phone Number
Address		Zip Code	Patient language (for handouts)
Flu Clinic: Date	Flu Clinic: Day of the Week	Flu Clinic: Start Time	Flu Clinic: End Time
Drop-off Location for Supplies			
Address		Zip Code	Phone Number
Drop-off Location for Vaccines			
Address		Zip Code	Phone Number
Primary Contact Person			
First Name	Last Name	Phone Number	Email
Secondary Contact Person			
First Name	Last Name	Phone Number	Email
Amount of Vaccine Requested			
Number of doses requested		Do you need nursing students to help at your clinic?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

