



Clinic Name _____

Clinic Address: _____

Phone: _____ Fax: _____ E-mail: _____

Contact Name(s): _____

Employer Identification Number (Tax ID Number): _____

Is the clinic a Federally Qualified Health Center? Yes No

In order to participate in the Vaccines For Adults At Risk (VFAAR) program and receive federally procured vaccines at no cost to me, I, on behalf of myself and any/all other practitioners associated with this medical clinic (or other entity) of which I am physician-in-chief (or the equivalent), agree to the following:

1. VFAAR vaccines will only be administered to VFAAR eligible, uninsured adults (aged 19 through 64 years).
2. Before initial administration of vaccine obtained through the VFAAR program, I will screen the patient for eligibility.
3. I will not impose a charge for the cost of VFAAR vaccines to the patient or the Department of Public Welfare/Medical Assistance or any public/private insurance carrier.
4. I will not deny the administration of federally procured vaccine to a VFAAR-eligible adult due to the inability of the patient to pay an administration fee.
5. I will maintain patient-specific records for all adults immunized with VFAAR vaccines, which must be reported to the KIDS Plus Registry either electronically or through paper logs. This is a BOH requirement as per the law "Regulations Governing the Immunization of Adults," passed 08/13/2009.
6. I will comply with the immunization schedule, dosage and contraindications that are established by the Advisory Council on Immunization Practices (ACIP) unless (a) in making a medical judgment in according with accepted medical practice, I deem such compliance to be medically inappropriate, or (b) the particular requirement is not in compliance to the law of Pennsylvania, including the laws relating to religious and philosophical exemptions.
7. I will comply with the Philadelphia Department of Public Health's (PDPH) requirements for ordering vaccine and other requirements as outlined by the VFAAR Program such as ordering and accounting for all product supplied by VFAAR (including expired vaccine), reporting of short-dated vaccine, and reporting of spoiled/wasted vaccine. Doses that are wasted or expired must be reimbursed to the VFAAR Program.
8. I will abide by all appropriate protocols for the storage and handling of immunobiologics as specified by the Philadelphia Department of Public Health.
9. I will maintain appropriate temperature logs for VFAAR products, recording temperatures twice each day my facility is in operation.
10. I agree to periodic site visits from VFAAR Program staff, both announced and unannounced visits.
11. I understand that the VFARR Program is funded through a federal grant that is awarded annually, therefore the Immunization Program cannot guarantee that the VFAAR program will be sustained from year to year, and that VFAAR can not be held accountable if funding decreases.
12. I will distribute the most current versions of the Vaccine Information Statements (VIS) each time a vaccine is administered and I will maintain records, which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
13. I, or the PDPH, may terminate this agreement at any time for personal reasons or failure to comply with these requirements.

Physician Signature: _____ Date: _____

Print Name: _____

VACMAN ID #: _____	VFAAR Effective Date: _____	Date Certified for 317: _____
For PDPH Use Only Updated: November 2012		