

H1N1 Provider Registration Form

A. Facility Name: _____

Contact Name(s): _____

First MI Last Title

**Vaccine Delivery
and Storage Address:** _____

Street Address (NO P.O. BOXES PLEASE)

City State Zip Code (+4 digit ext.)

Mailing Address: _____

(if different from above)

Street Address and/or P.O. Box Number

City State Zip Code (+4 digit ext.)

Email Address: _____

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

List times staff are available (Monday – Friday) to receive vaccine in your facility.

Monday	_____	Times: _____
Tuesday	_____	Times: _____
Wednesday	_____	Times: _____
Thursday	_____	Times: _____
Friday	_____	Times: _____

B. Storage equipment

Please check the type and size refrigeration unit(s) that will store the H1N1 vaccine

Pharmacy Grade Stand-alone Combination Household
_____ cu.ft. _____ cu.ft. _____ cu.ft.

Does your facility have a certified calibrated thermometer for each refrigeration unit? Yes _____ No _____

C. Indicate: **VFC Provider:** Yes _____ No _____ **Non-VFC Provider:** Yes _____ No _____
VFC PIN #: _____

D. Type of Vaccine Provider: (✓ one only)

- Public Health Department (10)
- Federally Qualified Health Center or Rural Health Center (15)
- Physician's Solo Practice (20)
- Physician's Group Practice (20)
- Public Hospital (12)
- Private Hospital (22)
- Other Public (16)
- Other Private (mass vaccination or retail companies (24)

E. Practice Specialty:

- Pediatrics (Ped)
- General Practice (GP)
- Hospital (HOSP)
- DYS
- Family Practice (FP)
- Internal Medicine (IM)
- Multi-Specialty (Mult)
- Not Applicable – mass vaccination or retail setting

Medical Director or other Authorizing Agent

Date

Facility Name _____

Fax completed form to
(636) 949-1802

*Questions? Call (636) 949-7554
St. Charles County Department of
Community Health and the Environment*