VERMONT
DEPARTMENT OF HEALTH

2022 TO 2024 VERMONT ADULT VACCINE PROGRAM PROVIDER AGREEMENT

FACILITY INFORMATION

Facility Name:		Facility NPI:	VAVP Pin#:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (*if different than facility address):*			
City:	County:	State:	Zip:

MEDICAL DIRECTOR OR EQUIVALENT

Instructions: *The official VAVP registered health care provider signing the agreement must be a practitioner authorized to administer adult vaccines under state law who will also be held accountable for compliance by the entire organization and its VAVP providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement.*

Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No. *(optional):*
Provide Information for second individual as needed:		
Last Name, First, MI:	Title:	Specialty:
License No.:	Medicaid or NPI No.:	Employer Identification No.: *(optional):*

VAVP VACCINE COORDINATOR

Primary Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ○ Yes ○ No	Type of training received:
Back-Up Vaccine Coordinator Name:	
Telephone:	Email:
Completed annual training: ○ Yes ○ No	Type of training received:

PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*

Instructions: *List below all licensed health care providers (MD, DO, NP, PA, pharmacist) at your facility who have prescribing authority.*

Provider Name	Title	License No.	Medicaid or NPI No.	EIN *(Optional)*

PROVIDER AGREEMENT

To receive publicly funded vaccines at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or equivalent:

1.	I will annually submit a VAVP enrollment form or more frequently if there is a change in Medical Director or the population served.
2.	I will screen patients and document patients age at each immunization encounter for VAVP eligibility and administer VAVP-purchased vaccine only to adults age 19-64. Adults aged 65 and older are **not** eligible to receive VAVP-purchased vaccine.
3.	For the vaccines identified and agreed upon in the provider profile, I will comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VAVP program unless: a) In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the adult; b) The particular requirements contradict state law, including laws pertaining to religious and other exemptions.
4.	I will maintain all records related to the VAVP program for a minimum of three years and upon request make these records available for review. VAVP records include, but are not limited to, VAVP screening documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, and vaccine purchase and accountability records.
5.	I will immunize eligible adults with publicly supplied vaccine at no charge to the patient for the vaccine.
6.	I will not deny administration of a publicly purchased vaccine to an established patient because the individual of record is unable to pay the administration fee.
7.	I will distribute the current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Adulthood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8.	I will comply with the requirements for vaccine management including: a) Ordering vaccine and maintaining appropriate vaccine inventories; b) Not storing vaccine in dormitory-style units at any time; c) Storing vaccine under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Vermont Vaccine Program storage and handling recommendations and requirements; d) Returning all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration
9.	I will participate in VAVP program compliance site visits including unannounced visits, and other educational opportunities associated with VAVP program requirements.

10.	Vermont health care providers must report to Vermont Department of Health immunization data for adults 18 years and older, within one month after the health care provider has established an electronic health records system and data interface pursuant to the e-health standards developed by the Vermont information technology leaders. (Vermont Statutes Annotated, 18, Chapter 21 § 1129. Immunization Registry).
11.	I understand this facility or the Vermont Vaccine Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the Vermont Vaccine Program.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Vermont Adult Vaccine Program enrollment requirements listed above and understand I am accountable (and each listed provider is individually accountable) for compliance with these requirements.	
Medical Director or Equivalent Name (print):	
Signature:	Date:
Name (print) *Second individual as needed*:	
Signature:	Date:

Number of adult patients	Total Number of Adults ages 19 – 64

Vermont Adult Vaccine Program (VAVP) Program
Provider Profile Form

All health care providers participating in the Vermont Adult Vaccine Program (VAVP) program must complete this form annually or more frequently if the number of Adults served changes or the status of the facility changes during the calendar year.

Date: ___ ___ /___ ___/ ___ ___ ___ ___ **Provider Identification Number#**_____

FACILITY INFORMATION		
Provider Name:		
Facility Name:		
Vaccine Delivery Address:		
City:	**State:**	**Zip:**
Telephone:	**Email:**	

PROVIDER TYPE (select only one provider type)

Please review the provider type definitions to assist with provider type selection.

- ☐ Addiction Treatment Center
- ☐ Birthing Hospital or Birthing Center
- ☐ Community Health Center
- ☐ Community Vaccinator (non-health department)
- ☐ Correctional Facility
- ☐ Family Planning Clinic (non-health department)
- ☐ Federally Qualified Health Center
- ☐ Hospital
- ☐ Indian Health Service, Tribal, or Urban Clinic
- ☐ Juvenile Detention Center
- ☐ Migrant Health Center
- ☐ Mobile Provider
- ☐ Pharmacy
- ☐ Private Practice (e.g., family practice, pediatric, primary care)
- ☐ Private Practice (e.g., family practice, pediatric, primary care) as agent for FQHC/RHC-deputized
- ☐ Public Health Department Clinic (state/local)
- ☐ Public Health Department Clinic (state/local) as agent for FQHC/RHC-deputized
- ☐ Refugee Health Clinic
- ☐ Rural Health Clinic
- ☐ School-Based Clinic (permanent clinic location)
- ☐ STD/HIV Clinic (non-health department)
- ☐ Teen Health Center (non-health department)
- ☐ Urgent Care Center
- ☐ Women, Infants, and Children (WIC) Clinic
- ☐ Other (specify) _____

If applicable, please indicate the specialty of the provider/practice (Select all that apply):

- ☐ Family Medicine
- ☐ Internal Medicine
- ☐ OB/GYN
- ☐ Preventive Medicine
- ☐ Other (specify) _____
- ☐ N/A

Is this provider site part of a hospital/healthcare system?

- ○ Yes
- ○ No
- ○ N/A or don't know

Facility Type (select one):

○ Private Facility (privately funded entity; non-governmental)
○ Public Facility (publicly funded or government entity)
○ Combination (funded with public and private funds)

Is this facility a mobile facility, or does this facility have mobile units?*

○ Yes
○ No

*A mobile unit is a dedicated vehicle with a primary purpose of providing medical services (e.g., immunization services).

SELECT VACCINES OFFERED

○ Hepatitis A
○ Hepatitis B
○ MENB
○ HPV
○ Influenza
○ Meningococcal Conjugate
○ MMR
○ Pneumococcal Conjugate
○ Pneumococcal Polysaccharide
○ Polio
○ TD
○ Tdap
○ Varicella
○ Other, specify:

2022 to 2024 Provider Agreement and Guidelines for Frozen Vaccines

STORAGE REQUIREMENTS: If you wish to receive frozen vaccine you will have to complete this signed agreement showing that your practice meets the following guidelines for proper storage and handling.

a) Merck & Company, Inc. the manufacturer of frozen vaccine will pack and ship vaccine directly to the provider office after receiving an order from CDC which is submitted through Vaccine Inventory Management System (VIMS).

b) Vaccines **MUST** be stored in a freezer, and **MUST** maintain temperatures between -15°C to -50°C (+5°F to -58°F).

c) The freezer **MUST** have a separate door from the refrigerator, (e.g. stand alone freezer). Dorm-style or larger refrigerator/freezer combinations where the freezer is within the refrigerator is **NOT** acceptable.

d) A continues monitoring device (data logger) with current certificate of traceability and calibration must be placed in the freezer.

e) Freezer Max/Min temperatures must be recorded once a day as well as time and initials for each reading and any out of range temperatures **MUST** be reported to the Immunization Program immediately. Please call 1-802-863-7638.

f) State and/or VAVP supplied frozen vaccine **cannot be moved or redistributed from the provider site that received it without permission from the Vermont Immunization Program.**

Practice PIN: _____

Practice Name: _____

Vaccine Contact Name: _____

Contact Telephone Number: _____

I agree to the additional conditions herein for the storage, handling and use of varicella and zoster vaccine.

_____ _____

Signature of Medical Director or Equivalent **Date**