CALIFORNIA TDAP EXPANSION PROJECT

NEW PROVIDER ENROLLMENT FORM

Instructions for applying to the Tdap Expansion Project:

1. Fill out this form completely and sign the Provider Agreement
2. Submit completed form, and signed Provider Agreement to:

   Immunization Branch
   Attn: Tdap Expansion Enrollment
   850 Marina Bay Parkway, Building P
   Richmond, CA 94804

   Or fax documents to (877) 329-9832
3. Once your application and Provider Agreement have been reviewed and approved, a representative will contact you to schedule an onsite visit to review project details and requirements and to verify your refrigerator storage unit.

Practice Information/Shipping

NAME			
Vaccine Delivery / Shipping Address (No P.O. Box)		CITY	ZIP
Vaccine Delivery Address, Part 2		COUNTY	
EMPLOYER IDENTIFICATION NUMBER (EIN)	NATIONAL PROVIDER IDENTIFIER (NPI)	MEDI-CAL PROVIDER ○ yes ○ no	PUBLIC SITE ○ yes ○ no
CONTACT PERSON	Email	PHONE	FAX

PROVIDER TYPE

○ Public health department ○ Other public ○ Community Health Center (CHC)
○ Public hospital ○ Private hospital ○ Hospital outpatient clinic

Are you currently a VFC provider? ○ yes ○ no If yes: PIN _____ If no, are you interested in joining VFC? ○ yes ○ no

Mailing Address

CONTACT PERSON	CITY
MAILING ADDRESS	ZIP
MAILING ADDRESS, PART 2	

Vaccine Storage Units

INDICATE YOUR **REFRIGERATOR** STORAGE UNIT TYPES BELOW

Type:
○ Small/under counter ○ Combination
○ Stand alone refrigerator ○ Commercial/pharmacy grade
Number of Units: ☐

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Patient Estimates

- Estimate the total number of pregnant/post-partum women seen at your hospital/clinic last year
- Estimate the total number of adult (age 19 and up) infant contacts seen at your practice last year

Provider of Record

Instructions: *You must use this form to list the Provider of Record at your facility with prescription writing privileges who will administer State-provided vaccines.*

Last Name	First Name	National Provider ID (NPI)	Medical License Number	Title	Specialty code

E-mail Communication

Provider of Record E-mail Address for receiving communications

Additional Email Addresses to receive communications

1
2
3
4

Chief Physician (signature) | Date | Chief Physician Name (print) | Medical License Number

**By signing this provider agreement, I am confirming that I have/will have a Tdap Post-partum policy in place prior to administering Tdap vaccines received.*

PROVIDER AGREEMENT FOR RECEIPT OF STATE-SUPPLIED VACCINE

NAME OFFICE, PRACTICE, CLINIC, ETC			
CITY		COUNTY	ZIP
CONTACT PERSON		PHONE	
TITLE	NATIONAL PROVIDER IDENTIFIER (NPI)	FAX	EMAIL

As a condition for receiving vaccines from the California Department of Public Health (CDPH) at no cost, I agree to the following conditions, on behalf of myself and all practitioners, nurses and others associated with this medical office or setting or other health delivery facility of which I am the physician-in-chief or equivalent:

1. I will permit visits to my facility by authorized representatives of the State to review my compliance with program requirements including vaccine storage and record-keeping.
2. I will ensure that my vaccine storage refrigeration unit meets the requirements of the CDPH Immunization Branch Vaccine Storage Equipment Requirement. Acceptable vaccine storage equipments must meet the following requirements:
   - Be a refrigerator-only unit.
   - Maintain required vaccine storage temperatures (35°F – 46°F) year-round.
   - Be automatic defrost (frost-free) and free of any frost, ice, water or coolant leaks. Manual defrost (cyclic defrost) refrigerators with visible cooling plates/coiling in the internal back wall are not acceptable.
   - Provide enough space to store the largest number of doses expected at one time, allowing for vaccine storage at least 2-3 inches away from walls, floor, and other boxes, and away from cold air vents.
   - Be reliable (with a quiet compressor) and has not needed frequent repairs.
   - Have a door that seals tightly and closes properly.
   - Not have convertible features that switch to an all-freezer unit.
   - Have a working thermometer placed centrally in the unit. Thermometers must be certified in accordance with National Institute of Standards and Technology (NIST).
   - Be used only for vaccine storage.
3. I agree to store and handle State-supplied vaccines in accordance with the manufacturer's specification and only at the facility stipulated in this agreement.
4. Upon arrival of vaccine shipments, I will immediately receive the vaccine shipment, inspect shipment to verify temperature monitors indicate that vaccines have not be exposed to temperatures outside of range, and verify shipment contents. I will report any issue with vaccine shipments immediately to the State at (877) 243-8832 or my immunization field representative.
5. I will store vaccines at the recommended temperature of 35° F – 46° F (Aim for 40° F to keep temperatures from getting too warm or cold. If temperature is out of range, I will take immediate action to correct improper vaccine storage condition and document actions taken on the temperature log and contact the State immediately.
6. I will check refrigerator temperatures twice a day and use the State-provided Fahrenheit (F) Temperature Log or Celsius (C) Temperature Log on all cold storage units that contain vaccines, and retain the "Temp Log" (IMM-682) record each month for a period of thirty-six (36) months.
7. I will maintain and rotate vaccine stock by placing short-dated vaccines in front. I will call the State if I have any vaccines that will expire within 3 months. I will keep vaccine in original packaging until time of use.
8. I will be financially responsible for the replacement cost of any State-supplied vaccines that I receive for which I cannot account or that spoiled or expired because of negligence.
9. I will screen patients for immunization record and history prior to administering State-supplied vaccine to patients 19 years of age or older who come into my medical office for service.
10. I will administer State-supplied vaccines to patients in my practice in compliance with the recommended immunization schedule, dosage, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP), unless:
    a. In my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or
    b. The particular requirement contradicts the law in my State pertaining to religious and other exemptions.
11. I will make available a current copy of the Vaccine Information Statement(s) (VIS) for review prior to administering vaccines and will provide a written copy of the VIS or instructions for obtaining an electronic copy. I will document the VIS publication date in accordance with the National Childhood Vaccine Injury Act.
12. I will not charge patients or third party payers (including CHDP and Medi-Cal) a fee for the cost of vaccine provided by the State. Such a charge will result in a report of possible fraudulent activity to the State Attorney General's Office. I understand that a charge to offset direct costs for administration of vaccine is discouraged, but not specifically prohibited. I will not impose a charge for the administration of the vaccine that is higher than the maximum fee established by the State. (The current maximum for the State of California is $17.55 per dose administered.). Should I decide to charge an administration fee for vaccine injection, a sign/poster must be prominently displayed indicating that vaccine provided through public funds cannot be denied for inability to pay the administration fee. Administration fees cannot vary between vaccines. Administration fees may be reimbursed through Medi-Cal for eligible patients.
13. I will comply with the State's requirements for ordering vaccine as outlined on the State order forms, etc. (e.g., reporting via the order forms my previous vaccine usage and my current inventory of vaccine, etc.).
14. I will designate one fully trained staff member to be the primary vaccine coordinator to oversee vaccine ordering, vaccine management, inventory, storage and handling, and temperature monitoring. I will designate at least one person to be the back-up.
15. I understand that the State may terminate this agreement at any time for failure to comply with these requirements or without cause.
    Note: I understand that if this agreement is terminated, I must return to the State all unused (viable and non-viable) vaccines. I will also comply with the State's procedures for return of vaccines.

Chief Physician (signature)	Date	Chief Physician Name (print)	Medical License Number