



# MassHealth Flu Vaccine Program Provider Application

Please complete and submit this application along with all other required documentation.

## General Information

**1.** Local public health department or public school district name

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**2.** Legal entity mailing address

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**3.** City

**4.** State

**5.** Zip code (Enter 9-digit zip code if known.)

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**6.** Telephone

**7.** E-mail address

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**8.** Tax ID

**9.** National provider ID (NPI)

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## Flu Vaccine Provider Application Certification (Please read carefully and sign.)

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Provider's signature \_\_\_\_\_

*(Signature and date stamps, or the signature of anyone other than the provider or a person legally authorized to sign on behalf of a legal entity, are not acceptable.)*

\_\_\_\_\_  
 Printed legal name of provider

\_\_\_\_\_  
 Printed legal name of individual signing  
*(if the provider is a legal entity)*

\_\_\_\_\_  
 Date