Reset Form

IMMUNIZATION PROVIDER CONTACT REQUEST

State Form 54048 (R / 2-15)
Indiana State Department of Health, Immunization Program

INSTRUCTIONS: *1. Please complete the information below to be contacted about offering the Vaccines for Children or Adult Vaccine program, to schedule an Immunization Training, or to receive information about the CHIRP Immunization Registry.*
2. Fax completed form to (317) 233-3719.

A. Provider Information

Facility Name _____ Date of Request *(month, day, year)* _____

Mailing Address *(number and street)* _____

City _____ ZIP Code _____ County _____

Telephone _____ Fax _____

Contact Name and Email Address _____

Medical Director Name and NPI Number _____

B. I would like an Immunization Program representative to contact me about *(Check all that apply.)*

Enrolling in the Vaccines for Children (VFC) program	☐ Yes	☐ No
Enrolling in the Adult Vaccine program	☐ Yes	☐ No
Enrolling in the CHIRP Immunization Registry	☐ Yes	☐ No
Scheduling immunization trainings	☐ Yes	☐ No
Other _____	☐ Yes	☐ No

C. Practice Characteristics (*Only complete if requesting to be contacted regarding **VFC or Adult enrollment**.)*

Do you have a stand-alone* refrigerator?	☐ Yes	☐ No
Do you have a stand-alone* freezer?	☐ Yes	☐ No
Do you currently carry privately purchased vaccine?	☐ Yes	☐ No
Do you administer all CDC/ACIP recommended vaccines?	☐ Yes	☐ No

Name and Title of primary person to manage vaccines _____

Name and Title of back up person to manage vaccines _____

* A stand-alone refrigerator or freezer is a unit that refrigerates and/or freezes ONLY. These units are typically not attached to another type of storage unit.

D. Additional Information:

_____

_____

_____

_____

E. How did you hear about our programs?

☐ Another provider
☐ During an immunization presentation
☐ An Immunization Program Representative
☐ Currently a VFC/Adult vaccine provider
☐ Conference Exhibit
☐ Online
☐ Other _____