IMMUNIZATION PROVIDER DISENROLLMENT

State Form 54840 (10-11)
Indiana State Department of Health, Immunization Division

INSTRUCTIONS: 1. This form must be completed for individual public and private facilities who are no longer participating in as a publicly funded vaccine provider. By completing this form, you will no longer be able to received publicly funded vaccine for eligible children.
2. Fax this completed form to the Vaccine Manager at 317/972-0111.

A. Provider Information

Facility Name _____ Provider PIN Number _____

Medical Officer Name _____ (MD DO NP ___) Physician License Number_____

Contact Name _____ Email Address _____

B. Reason for Disenrollment

- ☐ Facility Closed
- ☐ Facility Merged with another location
- ☐ No longer wishes to offer publicly funded vaccine
  - ☐ Does not see enough patients
  - ☐ Dissatisfaction with program

  Please explain: _____

  _____
- ☐ Medical Officer Changed (Departed/Deceased)
  - ☐ New officer will be enrolling
  - ☐ New officer will not be enrolling
- ☐ Other _____

Signature _____ Date *(month, day, year)* _____
(Medical Officer listed in Section A.)

For Office Use Only

Date Form Received *(month, day, year)* _____

Date Entered into Vacman *(month, day, year)* _____ Entered by _____

Actions Taken *(Check all that apply.)*

☐ PIN Inactivated ☐ Field Representative Notified to transfer vaccine