Facility Name:
VFC PIN:

VACCINE RESTITUTION REPORT

VFC-enrolled may be required to replace vaccine that has been wasted due to negligence or failing to store or handle vaccine appropriately. **Vaccine restitution will occur on a dose for dose basis and must be tracked and reported to the Indiana State Department of Health for tracking purposes.**

COMPLETE THIS FORM WHEN:

- Dose for dose replacement is required by ISDH to report use of privately-purchased vaccine being administered to a VFC-eligible child

HOW TO COMPLETE THIS FORM:

- Enter information on each dose of vaccine replaced in a separate row in the Vaccine Restitution Report Table.
- All columns must be completed for each dose replaced
- The provider must sign and date at the bottom of this report
- Do not forget to record the lot number of the vaccine borrowed and the vaccine returned, and to update your inventory in CHIRP.

WHAT TO DO WITH THIS FORM:

- Providers must submit their borrowing form to the Immunization Division by fax monthly. Completed forms must be retained as a VFC program record and made available to the Indiana State Department of Health Immunization Program upon request.

Date Range of Vaccine Reporting (date of first dose replaced to date of last dose replaced): ____/____/____ to____/____/____

VACCINE RESTITUTION REPORT TABLE						
A **Vaccine Type Replaced**	**B** **Lot Number**	**C** **Patient Name**	**D** **Patient DOB** (XX/XX/XXXX)	**E** **Date Dose Administered** (XX/XX/XXXX)	**F** **VFC Eligibility Met** **(Uninsured, Underinsured, Medicaid, AI/AN)**	**G** **Date Dose Returned to Appropriate Stock** (XX/XX/XXXX) **AND** **Lot #**
I hereby certify, subject to penalty under the False Claims Act (31 U.S.C. § 3730) and other applicable Federal and state law, that VFC vaccine dose replacement reported on this form has been accurately reported and conducted in conformance with VFC provisions for such borrowing and further certify that all VFC doses borrowed during the noted time period have been fully reported on this form.						
Provider Name:			**Provider Signature:**			**Date:**