



## Vaccines for Children (VFC) Status Screening Comprehensive Certification Form for Children who are enrolled in Medicaid

*This form may be substituted for individual VFC screening records when 100% of the persons to be immunized at this facility are Medicaid enrolled.*

*Provider enrollment and Provider Profile forms for this practice must be on file with the WA State Department of Health. Certification must be re-issued annually when the provider profile and provider agreement are submitted.*

**Facility Name:**

**Date:**

**Address:**

**City:**

**State: WA**

**Zip Code:**

**Telephone:**

**FAX:**

**Email:**

### **SIGNATURE**

*By signing, I certify to the state/local/territorial immunization program that all children ages 0 through 18 years of age served by this practice are Medicaid enrolled.*

**Authorizing Official (print):**

**Authorizing Official Signature:**

**Date:**

*The authorizing official signing the certification must be a practitioner authorized to administer pediatric vaccines under state law.*

**Retain a copy of this form at your facility and send the original to:**

Attn: VFC QA Coordinator  
Washington State Department of Health  
Office of Immunization and Child Profile  
PO Box 47843  
Olympia WA 98504-7843