



FROZEN VACCINE NEW PROVIDER CERTIFICATION

LHJ: _____ PIN: _____

Clinic Name: _____

Shipping Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Fax: _____

Contacts

Name #1: _____ Name #2: _____

Shipping Days and Times:

Tues Wed Thurs Fri
AM _____ to PM _____ AM _____ to PM _____ AM _____ to PM _____ AM _____ to PM _____

THE FOLLOWING SECTION MUST BE COMPLETED TO RECEIVE VARICELLA VACCINE

Can freezer maintain a average temperature of 5F (-15C) or colder: yes or no

Does freezer have a separate, insulated door: yes or no

Frozen Vaccine may be stored in a non-frost free freezer

What type of temperature measuring device is used in freezer: _____

Signature: _____

Date: _____

If you have a disability and need this document in a different format, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).