

Washington State Adult Vaccine Program Enrollment Guide

Thank you for your interest in participating in the Washington State Adult Vaccine Program. This Enrollment Guide is intended for providers who are enrolling in the program for the first time.

If you are a re-enrolling provider, your facility contacts will receive an automated email when enrollment opens with a link to your pre-populated, facility specific provider agreement to update and sign. If you need to update your facility contacts, please reach out to us at WAAdultVaccines@doh.wa.gov.

Before you start the enrollment process, we suggest you take the following steps:

- Review this guide for instructions on how to complete the enrollment forms.
- Take images of your cold storage equipment unit(s) including the inside and outside of the storage unit you intend to use to store adult vaccines.
- Collect files of the calibration certificate(s) for each of your digital data loggers (DDLs) or temperature monitoring system.
- Collect 3 days of continuous temperature monitoring data for the current month showing stable, in-range temperatures.

Provider Application Inquiry

To enroll, organizations will complete the Adult Vaccine Program Provider Application [Inquiry](#). The Washington State Department of Health will review your organization's information and email the submitter a link to fill out the Adult Vaccine Program's full provider agreement. Receiving the link may take up to 48 hours. Once the full provider agreement link is received via email, please continue with the instructions below.


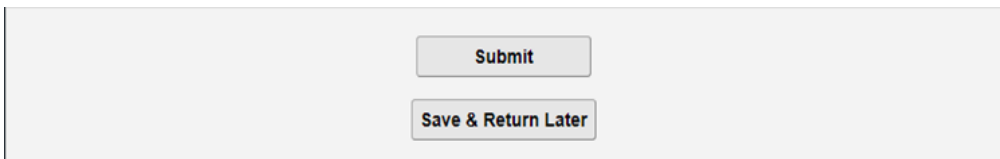
Provider Agreement

The provider agreement is separated into five (5) sections:

- Facility Information
- Practicing Providers
- Facility Availability for Shipments
- Facility Storage
- Agreements and Signatures

NOTE: If your organization plans to administer Adult Vaccine Program vaccines at multiple locations, you will need to complete a provider agreement for each location.

After submitting your provider agreement, the Program will review the application and follow up with any questions. If you have questions or need technical assistance, please contact the Washington State Department of Health Adult Vaccine Program at WAAdultVaccines@doh.wa.gov.

Getting Started	
Submitting Responses	<ul style="list-style-type: none"> At the end of each form, you will need to click "submit" to move onto the next section. 
Saving Progress	<ul style="list-style-type: none"> Select "Save & Return Later" at the end of a form. You can enter an email address to receive an emailed link to return to the page you left off at.  <p>Your survey responses were saved!</p> <p>You have chosen to stop the survey for now and return at a later time to complete it. To return to this survey, you will need the survey link to this survey.</p> <p>Survey link for returning You may bookmark this page to return to the survey, OR you can have the survey link emailed to you by providing your email address below. If you do not receive the email soon afterward, please check your Junk Email folder.</p> <p> <input type="text" value="Enter email address"/> <input type="button" value="Send Survey Link"/> </p> <p><small>* Your email address will not be stored</small></p> <p>The Program recommends getting your survey link regardless of whether you are leaving the survey. You can use the link later to confirm all sections were completed.</p>

Facility Information																													
Facility Information	<ul style="list-style-type: none"> These fields will be populated with information from the WAIS. You will not be able to change this information. Please email WAAdultVaccines@doh.wa.gov for additional support. <div> <table border="1"> <thead> <tr> <th colspan="4">Facility Information</th> </tr> </thead> <tbody> <tr> <td>Organization Name</td> <td colspan="3"></td> </tr> <tr> <td>Facility Name</td> <td colspan="3"></td> </tr> <tr> <td>Address</td> <td colspan="3"></td> </tr> <tr> <td>City</td> <td>State WA</td> <td>Zip</td> <td></td> </tr> <tr> <td>County</td> <td colspan="3"></td> </tr> <tr> <td>Telephone</td> <td></td> <td>Fax</td> <td></td> </tr> </tbody> </table> </div>	Facility Information				Organization Name				Facility Name				Address				City	State WA	Zip		County				Telephone		Fax	
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IIS Information for Facility	<ul style="list-style-type: none"> Review the WAIS Information for Facility and ensure it is correct. If it is not correct, please contact the WAIS Help Desk at 1-800-325-5599 or WAISHelpDesk@doh.wa.gov. <div> <table border="1"> <thead> <tr> <th colspan="2">IIS Information for Facility</th> </tr> </thead> <tbody> <tr> <td>Enrolled in Childhood Vaccine Program?</td> <td></td> </tr> <tr> <td>Organization WAIS ID</td> <td></td> </tr> <tr> <td>Facility WAIS ID</td> <td></td> </tr> <tr> <td>Facility PIN</td> <td></td> </tr> </tbody> </table> </div>	IIS Information for Facility		Enrolled in Childhood Vaccine Program?		Organization WAIS ID		Facility WAIS ID		Facility PIN																			
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Vaccine Shipment	<ul style="list-style-type: none"> Select whether your facility vaccine shipment address is different from your facility mailing address. <div> <p>Does your vaccine shipment address differ from your facility mailing address? <small>* must provide value</small></p> <div> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="reset"/> </div> </div> <ul style="list-style-type: none"> If you select yes, a new section will open asking for the vaccine shipment address. Please double check the information in this section <div> <p>Does your vaccine shipment address differ from your facility mailing address? <small>* must provide value</small></p> <div> <input checked="" type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="reset"/> </div> <p>Please enter vaccine shipment address.</p> <table border="1"> <tbody> <tr> <td>Shipping Address</td> <td colspan="3"></td> </tr> <tr> <td></td> <td colspan="3"><small>35 characters remaining</small></td> </tr> <tr> <td>City</td> <td></td> <td>State WA</td> <td>Zip</td> </tr> <tr> <td>County</td> <td colspan="3"></td> </tr> <tr> <td>Telephone</td> <td colspan="3"></td> </tr> </tbody> </table> </div>	Shipping Address					<small>35 characters remaining</small>			City		State WA	Zip	County				Telephone											
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Medical Director or Equivalent(s)	<ul style="list-style-type: none"> The signing provider must be a practitioner authorized to prescribe adult vaccines under WA State law. This individual will be held accountable for compliance by the entire facility and its providers. For additional information, please review the program information at https://doh.wa.gov/public-health-healthcare-providers/public-health-system-resources-and-services/immunization/adult-vaccine-program. <div data-bbox="537 569 1333 1052"> <table border="1"> <thead> <tr> <th colspan="4">Medical Director or Equivalent (Must provide value)</th> </tr> </thead> <tbody> <tr> <td>First Name</td> <td><input type="text"/></td> <td>Middle Initial</td> <td><input type="text"/></td> </tr> <tr> <td>Title</td> <td><input type="text"/></td> <td>Specialty</td> <td><input type="text"/></td> </tr> <tr> <td>License No.</td> <td><input type="text"/></td> <td>NPI No.</td> <td><input type="text"/></td> </tr> <tr> <td>EIN (optional)</td> <td><input type="text"/></td> <td>Email</td> <td><input type="text"/></td> </tr> <tr> <td colspan="4">Provide Information for a second individual as needed</td> </tr> <tr> <td>First Name</td> <td><input type="text"/></td> <td>Middle Initial</td> <td><input type="text"/></td> </tr> <tr> <td>Title</td> <td><input type="text"/></td> <td>Specialty</td> <td><input type="text"/></td> </tr> <tr> <td>License No.</td> <td><input type="text"/></td> <td>NPI No.</td> <td><input type="text"/></td> </tr> <tr> <td>EIN (optional)</td> <td><input type="text"/></td> <td>Email</td> <td><input type="text"/></td> </tr> </tbody> </table> </div>	Medical Director or Equivalent (Must provide value)				First Name	<input type="text"/>	Middle Initial	<input type="text"/>	Title	<input type="text"/>	Specialty	<input type="text"/>	License No.	<input type="text"/>	NPI No.	<input type="text"/>	EIN (optional)	<input type="text"/>	Email	<input type="text"/>	Provide Information for a second individual as needed				First Name	<input type="text"/>	Middle Initial	<input type="text"/>	Title	<input type="text"/>	Specialty	<input type="text"/>	License No.	<input type="text"/>	NPI No.	<input type="text"/>	EIN (optional)	<input type="text"/>	Email	<input type="text"/>
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Primary and Back-up Vaccine Coordinators	<ul style="list-style-type: none"> Some of this information may be pre-populated. Ensure that the annual DOH- specific vaccine coordinator training requirements are completed and that you have saved your course transcript to upload with your agreement. Primary and back-up vaccine coordinators must complete this annual training requirement within the current calendar year. <p>For facilities enrolled in BOTH the Adult Vaccine Program AND the Childhood Vaccine Program:</p> <ul style="list-style-type: none"> Please use these instructions to get started. The instructions review how to create an account on Train.org, register for and access the required training modules, complete assessments, and receive a continuing education certificate (optional). You may bookmark the link for future use. <p>For facilities enrolled in ONLY the Adult Vaccine Program:</p> <ul style="list-style-type: none"> Please use these instructions to get started. The instructions review how to create an account on Train.org, register for and access the required training modules, complete assessments, and receive a continuing education certificate (optional). You may bookmark the link for future use. 																																								



Primary and
Back-up
Vaccine
Coordinators
cont.

Clinic Coordinators for Test Facility

Instructions: There must be separate primary and back-up vaccine coordinators. Vaccine coordinators are required to complete annual training. The Department of Health (DOH) Vaccine Coordinator Training is a required annual training for vaccine coordinators participating in the Childhood and Adult Vaccine Programs to ensure the administration of safe and effective vaccines. Complete the modules and post-tests to obtain the required training transcript. Completion of this training must be the same year the agreement is submitted.

For facilities enrolled in BOTH the Adult Vaccine Program AND the Childhood Vaccine Program: Please [use these instructions to get started](#). The instructions review how to create an account on Train.org, register for and access the required training modules, complete assessments, and receive a continuing education certificate (optional). You may bookmark the link for future use.

For facilities enrolled in ONLY the Adult Vaccine Program: Please [use these instructions to get started](#). The instructions review how to create an account on Train.org, register for and access the required training modules, complete assessments, and receive a continuing education certificate (optional). You may bookmark the link for future use.

Primary Vaccine Coordinator			
First Name	<input type="text"/>	Last Name	<input type="text"/>
Phone #	<input type="text"/>	Ext:	<input type="text"/>
Email	<input type="text"/>		
Completed the DOH Vaccine Coordinator training?	<input type="button" value="Yes"/> <input type="button" value="No"/>		Completion date for the DOH Vaccine training (MM/DD/YY) <input type="text"/>  Today M-D-Y
	<input type="button" value="reset"/>		
Upload the Primary Vaccine Coordinator Training Transcript Image	<input type="button" value="Upload file"/>		
Back-Up Vaccine Coordinator			
First Name	<input type="text"/>	Last Name	<input type="text"/>
Phone #	<input type="text"/>	Ext:	<input type="text"/>
Email	<input type="text"/>		
Completed the DOH Vaccine Coordinator training?	<input type="button" value="Yes"/> <input type="button" value="No"/>		Completion date for the DOH Vaccine training (MM/DD/YY) <input type="text"/>  Today M-D-Y
	<input type="button" value="reset"/>		
Upload the Back-up Vaccine Coordinator Training Transcript Image	<input type="button" value="Upload file"/>		
Would you like to add additional contacts? <small>* must provide value</small>		<input type="button" value="Yes"/> <input type="button" value="No"/>	

Facility Type	<ul style="list-style-type: none"> Select the locations for facility type. <div> <div>Facility Type</div> <div> <div>Facility Type</div> <div>* must provide value</div> <div> <div>Private - privately funded; non-governmental</div> <div>Public - publicly funded or government entity</div> <div>Combo - funded with public and private funds</div> </div> </div> </div>
Federally Qualified Health Center	<ul style="list-style-type: none"> Select if your facility is a Federally Qualified Health Center. If you select "no" additional questions will populate. <div> <div>Is your facility a Federally Qualified Health Center*?</div> <div> <div>*Community-based health care provider that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. This provider type is used for federally qualified health centers (FQHCs) that provide vaccination services. NOTE: For tribal or urban Indian health clinics enrolled as FQHCs, use the "Indian Health Service, Tribal, or Urban Clinic" designation.</div> <div> <div>Yes</div> <div>No</div> </div> <div>reset</div> </div> </div>
Rural Health Program	<ul style="list-style-type: none"> Select if your facility is a Rural Health Program. If you select "no" additional questions will populate. <div> <div>Is your facility a certified Rural Health clinic through the Washington State DOH Rural Health Program?</div> <div> <div>Click here for more information on what that means.</div> <div> <div>Yes</div> <div>No</div> </div> <div>reset</div> </div> </div>
Provider Type	<ul style="list-style-type: none"> Pick the type that best applies to your facility and follow the prompts. If you select "other" an additional box will appear where detailed information can be entered. For additional details on Provider Types, please view the Appendix-Provider Types.

	<p>Provider Type (select only one provider type):</p> <p><small>* must provide value</small></p> <div> <div>Addiction Treatment Center</div> <div>Birthing Hospital or Birthing Center</div> <div>Community Health Center</div> <div>Community Vaccinator (non-health dept)</div> <div>Correctional Facility</div> <div>Family Planning Clinic (non-health dept)</div> <div>Hospital</div> <div>IHS, Tribal, or Urban Clinic</div> <div>Juvenile Detention Center</div> <div>Mobile Provider</div> <div>Pharmacy</div> <div>Private Practice</div> <div>Public Health Department (state/local)</div> <div>Refugee Health Clinic</div> <div>School-Based Clinic (permanent clinic location)</div> <div>STD/HIV Clinic (non-health dept)</div> <div>Teen Health Center (non-health dept)</div> <div>Urgent Care Center</div> <div>Women, Infants, and Children (WIC) Clinic</div> <div>Other (specific):</div> </div>
<p>Mobile Facility Information</p>	<ul style="list-style-type: none"> There is the option for mobile units. Please note if you select yes, you will be directed to enter additional storage and handling information for mobile storage units and DDLs. <div> <p>Is this a mobile facility or does your facility have mobile units?</p> <p><small>*Answer yes if immunization services are offered primarily through mobile clinics or the facility has a mobile unit that provides some immunization services. *</small></p> <div> <div>Yes</div> <div>No</div> </div> <p><small>reset</small></p> </div>

	<ul style="list-style-type: none"> Select a response to the remaining questions in that section. <div> <p>Does your facility require patients be established in order to be vaccinated? <small>* must provide value</small></p> <div> <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="reset"/> </div> </div> <div> <p>How does your facility offer immunization services to uninsured patients? (Choose all the apply.) <small>* must provide value</small></p> <div> <input type="button" value="+ During scheduled appointments"/> <input type="button" value="+ Walk-in vaccinations"/> <input type="button" value="+ Off-site vaccinations"/> <input type="button" value="+ Vaccination-only appointments"/> <input type="button" value="+ Dedicated days/ times for vaccinations"/> <input type="button" value="+ Other (specify)"/> </div> </div> <div> <p>Is an office fee charged in addition to any vaccine administration fees? <small>* must provide value</small></p> <div> <input type="button" value="Yes"/> <input type="button" value="No"/> </div> </div>
<p>Patient Population</p>	<ul style="list-style-type: none"> Report the number of uninsured patients (19-65 years of age) served by your facility in the last 12 months. If "other" is selected for type of data used, an additional description box will pop up asking for additional information. <div> <p>Uninsured Patients <small>* must provide value</small></p> <input type="text"/> </div> <div> <p>Type of Data Used to Determine Patient Population (Choose all that apply) <small>* must provide value</small></p> <div> <input type="button" value="+ Provider Billing System"/> <input type="button" value="+ IIS"/> <input type="button" value="+ Other (must describe):"/> </div> </div>
<p>Vaccine Selection</p>	<ul style="list-style-type: none"> Rank in priority order up to) five (5) vaccine products that your facility is interested in for the upcoming budget year. <p>Leave fields blank if there are less than five (5)types you are interested in ordering for your uninsured patients. If a facility would like to offer COVID-19 vaccine through the Adult Vaccine Program, it must be indicated in this section by selecting it as an option.</p>

Vaccine Selection

Instructions: Rank in priority order up to 5 vaccine products that you'd like to have available for your facility through the Adult Vaccine Program for the 2025-2026 budget year for uninsured adults. Leave fields blank if interested in less than 5 types of vaccine. Please consider these options carefully as you will not have the option to change your selections until the next enrollment period in June 2025.

Keep in mind:

- Your AVP order sets will only contain the vaccine products you select in this section.
- Your ranking will help us prioritize your preferred vaccine products during the AVP allocation process in the event we cannot fill all requests due to funding limitations.
- This not a vaccine request or order. Official vaccine requests will be announced in the AVP newsletter and typically occur in the spring and fall.
- You are not guaranteed to receive an allocation of the vaccine types selected.
- Leave fields blank if you wish to request less than 5 vaccine types.
- You must select the COVID-19 vaccine as one of your top 5 priorities if you wish to request COVID-19 vaccine through AVP this fall. COVID-19 vaccine eligibility is limited to uninsured adults only.
- Do not select more than 1 brand of each vaccine in your top 5. For example, do not prioritize 2 Hepatitis A products (i.e. Vaqta & Havrix) or 2 Tdap products (i.e. Adacel and Boostrix).

Vaccines offered:

- | | |
|---|---|
| <ul style="list-style-type: none"> • COVID-19 • EIPV- IPOL • Flu- Fluarix Quad • Hep A- Havrix • Hep A- Vaqta • Hep B- Engerix-B • Hep B- Recombivax HB • Hep B- Heplisav-B • Hep A/ Hep B- TWINRIX • HPV 9- Gardasil | <ul style="list-style-type: none"> • MMR- Priorix • MMR- M-M-R®II • Mpox- JYNNEOS • PCV20- Prevnar 20 • PCV21-Capvaxie • RSV- Abrysvo • RSV- Arexvy • Tdap- Adacel • Tdap- Boostrix • Zoster (Shingles)- Shingrix |
|---|---|

Priority Level	#	Vaccine Selection
Highest	1.	<input type="text"/>
	2.	<input type="text"/>
	3.	<input type="text"/>
	4.	<input type="text"/>
Lowest	5.	<input type="text"/>

Practicing Providers

Number of Providers

- Enter the number of providers that practice at your facility. This will open the corresponding number of provider boxes.
- If you have more than 15 providers, you will click and download the "Practicing Providers_Template" above the submit button. You will be able to enter additional provider information there.


Instructions: List all licensed health care practitioners (MD, DO, NP, PA, pharmacist, etc.) at your facility who have prescribing authority.

This form allows up to 15 providers to be added. If the facility has more than 15 providers, please upload the required information for additional providers using the attached template.

How many practicing providers do you have at your facility?

Provider 1	
Provider Name (First, Last)	<input type="text"/>
Title (MD, NP, PA, etc.)	<input type="text" value="v"/>
Specialty	<input type="text"/>
Medical License No.	<input type="text" value="2 letters, 8 digit number"/> <small>10 characters remaining</small>
NPI No.	<input type="text"/> <small>10 characters remaining</small>

Please use attached template to upload additional providers.

Attachment:  [Practicing_Providers_Template.xlsx](#) (12.7 kB)

Facility Availability for Shipments

Facility Shipment Information

- Select the button that corresponds to the shipping day you are entering time for.
- Enter the start and end times for each day your facility can receive shipments.

Facility Shipment Information

Instructions: Please enter your facility's availability for receiving vaccine shipments using 24 hour format. Facilities are required to be available for vaccine shipments a minimum of four consecutive hours two days a week Monday - Friday.

(Example: Tuesday 08:00am to 12:00pm & Wednesday 13:00pm to 17:00pm).

Please indicate vaccine shipment availability.

	All Day (No breaks in availability, AM to PM)	No availability	Available during specific hours (or break in facility's availability)
Mondays <small>* must provide value</small>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tuesdays <small>* must provide value</small>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Wednesdays <small>* must provide value</small>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Thursdays <small>* must provide value</small>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
Fridays <small>* must provide value</small>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>

reset

reset

reset

reset

reset

Mondays

All Day (24 hr, AM to PM)

Start	<input type="text"/>	<input type="button" value="Now"/>	H:M	End	<input type="text"/>	<input type="button" value="Now"/>	H:M
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Tuesdays

If no availability in either morning or afternoon, please leave that section blank.

Morning (00:00-11:59) AM

Start	<input type="text"/>	<input type="button" value="Now"/>	H:M	End	<input type="text"/>	<input type="button" value="Now"/>	H:M
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Afternoon (12:00-23:59) PM

Start	<input type="text"/>	<input type="button" value="Now"/>	H:M	End	<input type="text"/>	<input type="button" value="Now"/>	H:M
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Special Instructions or Limited Shipping Availability:

Expand

Facility Storage	
Cold Storage Equipment	<ul style="list-style-type: none"> Enter the number of storage units and how many of each type your facility has that will store Adult Vaccine Program vaccines. Please note, if the total number of storage units does not add up, you will need to correct it before moving forward. <div> <div>Cold Storage Equipment</div> <div>Please fill out the information below for each cold storage unit at the facility and those used in mobile units.</div> <div> <div>How many vaccine storage units does [redacted] have?</div> <div><input type="text"/></div> <div><small>* must provide value</small></div> <div><small>Not including portable vaccine storage units.</small></div> </div> <div> <div>Of these, how many are refrigerators?</div> <div><input type="text"/></div> <div><small>* must provide value</small></div> </div> <div> <div>Of these, how many are freezers?</div> <div><input type="text"/></div> <div><small>* must provide value</small></div> </div> <div> <div>Of these, how many are ultra-cold freezers?</div> <div><input type="text"/></div> <div><small>* must provide value</small></div> </div> </div>
Cold Storage Specifics	<ul style="list-style-type: none"> Enter the details for each type of storage unit that will store Adult Vaccine Program vaccines. You will need to upload proof of the brand/model of the storage unit(s) and certificate of calibration. You will also need to add 3 days of continuous temperature monitoring data for the current month showing stable, in-range temperatures. <div> <div>Cold Storage Specifics</div> <div>Instructions: Please enter information for each type of cold storage unit that will store vaccines. A photo for proof of brand/model, capacity and calibration certificate required for each unit listed.</div> <div> <div>Cold Storage 1 Name</div> <div>(Provide name for unit to reference during follow-up)</div> <div><input type="text"/></div> <div><small>* must provide value</small></div> <div><small>Provide name for unit to reference during survey and follow-up.</small></div> </div> </div>

Cold Storage
Specifics cont.

Cold Storage 1 - _____			
What type of storage equipment is this:	<input type="button" value="Refrigerator"/> <input type="button" value="Freezer"/> <input type="button" value="Ultra-cold Freezer"/> reset	Type of Unit (select one):	<input type="button" value="Commercial Standalone"/> <input type="button" value="Pharmaceutical/Medical"/> reset
Is this _____ also used to store Childhood Vaccine Program vaccines?	<input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="I am not a Childhood Vaccine Program provider"/> reset		
Manufacturer	<input type="text"/>	Model No.	<input type="text"/>
In Use Date	<input type="text"/> Today <small>M-D-Y</small>	Purchase Date	<input type="text"/> Today <small>M-D-Y</small>
Thermometer Brand	<input type="text"/>	Type of Thermometer	<input type="button" value="Digital Data Logger"/> <input type="button" value="Temperature Monitoring System"/> reset
Thermometer Model	<input type="text"/>	Temperature Scale	<input type="button" value="Celsius"/> <input type="button" value="Fahrenheit"/> reset
Date of Last Calibration	<input type="text"/> Today <small>M-D-Y</small>	Calibration Expiration Date	<input type="text"/> Today <small>M-D-Y</small>
Please upload a photo or other proof of the brand/model of the _____ for verification.	Upload file	Please upload calibration certificate	Upload file
Please upload 3 days of continuous temperature monitoring data for the current month for this unit. Upload file			
<p>Medical/Pharmacy Director Location's Vaccine Coordinator Storage Unit Attestation</p> <ul style="list-style-type: none"> The storage information submission requires a signature and date. If you have additional documents, such as transport equipment, qualified pack outs, or backup DDLs, that information can be attached here. <p>Medical/Pharmacy Director or Location's Vaccine Coordinator Storage Unit Attestation</p> <p>I attest that each unit listed will maintain the appropriate temperature range indicated above:</p> <p>(Medical/Pharmacy Director or Vaccine Coordinator Signature)</p> <p>* must provide value</p> <p>Add signature</p> <p>Date: <input type="text"/> Today <small>Y-M-D</small></p>			

Agreement and Signatures									
Provider Agreement Regulations	<ul style="list-style-type: none"> Review and save the regulations and requirements of participating in the program. You must have both signatures to submit the agreement. The survey link can be emailed to another person to sign. Ensure you have a copy of the survey link. 								
Medical Director Signature	<ul style="list-style-type: none"> The medical director of the facility will need to sign and date the agreement. <div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center; background-color: #0056b3; color: white; margin: -1px -1px 1px -1px;">Medical Director</p> <p>I understand and accept the conditions of this agreement and agree to comply with these requirements on behalf of myself and all the practitioners associated with this facility. I agree to inform all providers in the facility of their obligations under this agreement. The department may terminate this agreement at any time for failure to comply with program requirements. I may terminate this agreement at any time for personal reasons.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Medical Director Full Name:</td> <td><input type="text"/></td> </tr> <tr> <td>Medical Director License Number:</td> <td> <input type="text"/> <small>10 digits- 2 letters followed by 8 numbers 10 characters remaining</small> </td> </tr> <tr> <td>Medical Director Signature:</td> <td>Add signature</td> </tr> <tr> <td>Date:</td> <td> <input type="text"/> <input type="button" value="Today"/> Y-M-D </td> </tr> </table> </div>	Medical Director Full Name:	<input type="text"/>	Medical Director License Number:	<input type="text"/> <small>10 digits- 2 letters followed by 8 numbers 10 characters remaining</small>	Medical Director Signature:	Add signature	Date:	<input type="text"/> <input type="button" value="Today"/> Y-M-D
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Date:	<input type="text"/> <input type="button" value="Today"/> Y-M-D								
Primary Vaccine Coordinator	<ul style="list-style-type: none"> The Primary Vaccine Coordinator of this facility will also need to sign this agreement. <div style="border: 1px solid black; padding: 5px;"> <p style="text-align: center; background-color: #0056b3; color: white; margin: -1px -1px 1px -1px;">Primary Vaccine Coordinator</p> <p>I understand and accept the conditions of this agreement and agree to comply with these requirements on behalf of myself and all the practitioners associated with this facility. I agree to inform all providers in the facility of their obligations under this agreement. The department may terminate this agreement at any time for failure to comply with program requirements. I may terminate this agreement at any time for personal reasons.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Primary Vaccine Coordinator Full Name</td> <td><input type="text"/></td> </tr> <tr> <td>Primary Vaccine Coordinator Title</td> <td><input type="text"/></td> </tr> <tr> <td>Primary Vaccine Coordinator Signature</td> <td>Add signature</td> </tr> <tr> <td>Date</td> <td> <input type="text"/> <input type="button" value="Today"/> Y-M-D </td> </tr> </table> </div>	Primary Vaccine Coordinator Full Name	<input type="text"/>	Primary Vaccine Coordinator Title	<input type="text"/>	Primary Vaccine Coordinator Signature	Add signature	Date	<input type="text"/> <input type="button" value="Today"/> Y-M-D
Primary Vaccine Coordinator Full Name	<input type="text"/>								
Primary Vaccine Coordinator Title	<input type="text"/>								
Primary Vaccine Coordinator Signature	Add signature								
Date	<input type="text"/> <input type="button" value="Today"/> Y-M-D								
Signatures Complete	<ul style="list-style-type: none"> Once the agreement has been signed by both the Medical Director and the Primary Vaccine Coordinator, mark yes. Note: This field indicates application is completed. <div style="border: 1px solid black; padding: 5px;"> <p>Are all signatures complete? <small>* must provide value</small></p> <div style="display: flex; justify-content: space-around;"> <input type="button" value="Yes"/> <input type="button" value="No"/> </div> </div>								

Once this page is signed and submitted, your agreement will be reviewed.