

**This list of questions is for information purposes only.  
Please do not use it as the enrollment form!**

## **COVID-19 Vaccination Program Provider Enrollment**

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### **Organization's legal name\*:**

Organization's legal name can be different from organization location's name.  
Example: INTEGRIS Health is organization's legal name; INTEGRIS Bass Baptist Hospital is organization location's name. To answer this question, one will enter INTEGRIS Health.

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### **Number of affiliated vaccination locations covered by this agreement\*:**

Example: INTEGRIS Health enrolls 34 clinics and hospitals to receive and administer COVID-19

vaccine. To answer this question, one will enter 34. If organization enrolls only itself, one will enter 1 to answer this question.

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Organization telephone (format 123-456-7890)\*:

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Organization email (must be monitored and will serve as dedicated contact method for the COVID-19 Vaccination Program)\*:

- Must be less than 40 characters.
  - Must be monitored and will serve as a dedicated contact method for the COVID-19 Vaccination Program.
  - CDC will use this email address to email the registration link to Vaccine Finder
- 

State\*: (dropdown with states)

Organization address — County\*: (dropdown with OK counties)

Organization address — Street address 1\*:

Organization address — Street address 2:

Organization address — City\*:

ZIP\* (5-digit zip code or 9-digit zip code with "-" before the 4-digit delivery route 12345-1234):

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For the purposes of this agreement, in addition to Organization, Responsible Officers named below will also be accountable for compliance with the conditions specified in this agreement. At the end of this page, you must upload "Section A" signed by CMO and CEO of your organization.

CMO Contact Information

CMO — Last Name\*

CMO — First Name\*

CMO — Middle Initial

CMO — Title:\*

CMO — Licensure state:\*

CMO — Licensure number:\*

Not the enrollment form

CMO — Telephone (format 123-456-7890):\*

CMO — Email:\*

CMO — Street address 1:\*

CMO — Street address 2:

CMO — City\*:

CMO — State\*: (dropdown with states)

*Display This Question:*

*If CMO — State\*: = OK*

CMO — ZIP\*: (5-digit zip code or 9-digit zip code with "-" before the 4-digit delivery route 12345-1234)

### **CEO Contact Information**

CEO — Last Name\*

CEO — First Name\*

CEO — Middle Initial

CEO — Telephone (format 123-456-7890):\*

CEO — Email:\*

CEO — Street address 1:\*

CEO — Street address 2:

CEO — City\*:

CEO — State\*: (dropdown with states)

*Display This Question:*

*If CEO — State\*: = OK*

CEO — ZIP\*: (5-digit zip code or 9-digit zip code with "-" before the 4-digit delivery route 12345-1234)

CMO — Signature Date\* (yyyy/mm/dd):

CEO — Signature Date\* (yyyy/mm/dd):

**Upload "Section A. COVID-19 Vaccination Program Provider Requirements and Legal Agreement" signed by CEO (or Equivalent) and CEO (or Chief Fiduciary).**

Only PDF format is accepted. If your organization's CEO and CMO haven't signed the Section A form yet, please [download it](#) and provide to them to complete and sign.

If "Section A" form is signed by hand, it should be scanned and saved as a pdf document. Please do not email/fax/mail "Section A" forms to the Oklahoma State Department of Health! Only forms uploaded through this online enrollment will be accepted. The OSDH will receive "Section A" form when medical/pharmacy director or location's vaccine coordinator click "Submit" button at the end of this enrollment.

Today's date: (today's date is entered automatically, you cannot change it)

**Section B. CDC COVID-19 Vaccination Program Provider Profile Information**

Organization location/facility Name and Contact Information\*:

Facility Name \_\_\_\_\_

Facility Phone \_\_\_\_\_

Facility Fax \_\_\_\_\_

Will another Organization location order COVID-19 vaccine for this site?\*

☐ Yes

☐ No

*Display This Question:*

*If Will another Organization location order COVID-19 vaccine for this site?\* = Yes*

Provide the name of the Organization that will be ordering COVID-19 vaccine for this location\*:

Primary COVID-19 Vaccine Coordinator\*:

☐ Last Name \_\_\_\_\_

☐ First Name \_\_\_\_\_

☐ Telephone \_\_\_\_\_

☐ Email \_\_\_\_\_

Is there a Back-up COVID-19 Vaccine Coordinator?\*

☐ Yes

☐ No

*Display This Question:*

*If Is there a Back-up COVID-19 Vaccine Coordinator?\* = YES*

Back-up COVID-19 Vaccine Coordinator\*: (This may or may not be your VFC Back-up Contact)

- ☐ Last Name \_\_\_\_\_
- ☐ First Name \_\_\_\_\_
- ☐ Telephone \_\_\_\_\_
- ☐ Email \_\_\_\_\_

Facility Mailing Address: If your facility has the same shipping address as another facility please add a specification in the address for delivery (example: Attn Pharmacy, Ste Number, After hours clinic )

Street Address\* \_\_\_\_\_

City\* \_\_\_\_\_

State\* \_\_\_\_\_

Postal Code\* \_\_\_\_\_

Telephone\* \_\_\_\_\_

Fax \_\_\_\_\_

County\*: (dropdown with OK counties)

Is the Shipping Address the same as the Mailing Address?\*

- ☐ Yes
- ☐ No

*Display This Question:*

*If Is the Shipping Address the same as the Mailing Address?\* = No*

Facility Shipping Address: If your facility has the same shipping address as another facility please add a specification in the address for delivery (example: Attn Pharmacy, Ste Number, After hours clinic )

Street Address\* \_\_\_\_\_

City\* \_\_\_\_\_

State\* \_\_\_\_\_

Postal Code\* \_\_\_\_\_

Telephone\* \_\_\_\_\_

Fax \_\_\_\_\_

*Display This Question:*

*If Is the Shipping Address the same as the Mailing Address?\* = No*

County\*: (dropdown with OK counties)

Is the Mailing Address the same as the location's address where COVID-19 vaccine will be administered?\*

☐ Yes

☐ No

*Display This Question:*

*If Is the Mailing Address the same as the location's address where COVID-19 vaccine will be administ... = No*

Facility address where COVID-19 vaccine will be administered:

Street address\*: \_\_\_\_\_

City\*: \_\_\_\_\_

State\*: \_\_\_\_\_

ZIP\*: \_\_\_\_\_

Telephone\*: \_\_\_\_\_

Fax: \_\_\_\_\_

*Display This Question:*

*If Is the Mailing Address the same as the location's address where COVID-19 vaccine will be administ... = No*

County\*: (dropdown with OK counties)

### **Location's office hours\***

Please use military time format, 24h scale.

Example #1 "With a lunch break": a clinic works from 8:00am to 5:00pm with a lunch break from 1pm to 2pm. In this situation, one will document hours like this: AM: 08:00-13:00 / PM: 14:00-17:00.

Example #2 "Without a lunch break": a facility works from 8:00am to 5:00pm without a lunch break. In this situation, one will document hours like this: AM: 08:00-12:00 / PM: 12:00-17:00.

If a facility doesn't work on certain days, please enter CLOSED. All fields of the table must be filled in.

	Monday (1)	Tuesday (2)	Wednesday (4)	Thursday (5)	Friday (6)
AM: (1)					
PM: (2)					

**Days and times vaccine coordinators are available for receipt of COVID-19 vaccine shipments\***

Example #1 "With a lunch break": a clinic works from 8:00am to 5:00pm with a lunch break from 1pm to 2pm. In this situation, one will document hours like this: AM: 08:00-12:00 / PM: 12:00-13:00; 14:00-17:00.

Example #2 "Without a lunch break": a facility works from 8:00am to 5:00pm without a lunch break. In this situation, one will document hours like this: AM: 08:00-12:00 / PM: 12:00-17:00.



If a facility doesn't accept shipments on certain days, please enter CLOSED. All fields of the table must be filled in.

	Monday (1)	Tuesday (2)	Wednesday (4)	Thursday (5)	Friday (6)
AM: (1)					
PM: (2)					

Are the hours you accept deliveries the same as your office hours?\*

☐ Yes

☐ No

*Display This Question:*

*If If False*

Facility Type\*:

☐ CHD

☐ DHS

☐ FQHC

☐ Hospital - Private

☐ Hospital - Public

- ☐ IHS
- ☐ Military
- ☐ OSDH - Central Office
- ☐ Pharmacy
- ☐ Private
- ☐ Public
- ☐ RHC
- ☐ School
- ☐ State/Federal Agency

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*Display This Question:*

*If Facility Type\* = School*

Enter your district name and code

☐ School District Name (1) \_\_\_\_\_

☐ School District Code (2) \_\_\_\_\_

COVID-19 vaccination provider type for this location (select one)\*

Provider type can be the same as Facility type.

- ☐ Commercial vaccination service provider
- ☐ Corrections/detention health services
- ☐ Health center – community (non-Federally Qualified Health Center/non-Rural Health Clinic)
- ☐ Health center – migrant or refugee
- ☐ Health center – occupational
- ☐ Health center – STD/HIV clinic
- ☐ Health center – student
- ☐ Home health care provider
- ☐ Hospital
- ☐ Indian Health Service
- ☐ Tribal health
- ☐ Medical practice – family medicine
- ☐ Medical practice – pediatrics
- ☐ Medical practice – internal medicine
- ☐ Medical practice – OB/GYN
- ☐ Medical practice – other specialty
- ☐ Pharmacy – chain
- ☐ Pharmacy – independent
- ☐ Public health provider – public health clinic

- ☐ Public health provider – Federally Qualified Health Center
- ☐ Public health provider – Rural Health Clinic
- ☐ Long-term care – nursing home, skilled nursing facility, federally certified
- ☐ Long-term care – nursing home, skilled nursing facility, non-federally certified
- ☐ Long-term care – assisted living
- ☐ Long-term care – intellectual or developmental disability
- ☐ Long-term care – combination (e.g., assisted living and nursing home in same facility)
- ☐ Urgent care
- ☐ Other

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*Display This Question:*

*If COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same...  
= Other*

Please specify "Other" provider type for this location\*.

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*Display This Question:*

*If COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same...  
= Long-term care – nursing home, skilled nursing facility, federally certified*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same...  
= Long-term care – nursing home, skilled nursing facility, non-federally certified*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same...  
= Long-term care – assisted living*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same...  
= Long-term care – intellectual or developmental disability*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same...  
= Long-term care – combination (e.g., assisted living and nursing home in same facility)*

Number of staff members at this facility as of today: workers in residential health care settings who either work in situations where risk of transmission is high or are at an elevated risk of transmitting the infection to patients at high risk of mortality and severe morbidity\*.  
Enter "0" if the facility doesn't have these staff members.

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*Display This Question:*

*If COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same...  
= Long-term care – nursing home, skilled nursing facility, federally certified*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Long-term care – nursing home, skilled nursing facility, non-federally certified*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Long-term care – assisted living*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Long-term care – intellectual or developmental disability*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Long-term care – combination (e.g., assisted living and nursing home in same facility)*

Number of residents at this facility as of today: individuals living in residential health care settings that increase their risk of infection and resultant morbidity and mortality\*.

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*Display This Question:*

*If COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same...  
= Hospital*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Indian Health Service*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Tribal health*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Medical practice – family medicine*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Medical practice – internal medicine*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Urgent care*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Corrections/detention health services*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Corrections/detention health services*

Number of health care workers providing direct inpatient COVID care at this facility as of today: workers in acute/emergency health care settings who either work in situations where risk of transmission is high or are at an elevated risk of transmitting the infection to patients at high risk of mortality and severe morbidity\*.

Enter "0" if the facility doesn't have these staff members.

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*Display This Question:*

*If COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Public health provider – public health clinic*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Public health provider – Federally Qualified Health Center*

*Or COVID-19 vaccination provider type for this location (select one)\* Provider type can be the same... = Public health provider – Rural Health Clinic*

Number of public health staff conducting frontline COVID-19 pandemic mitigation and control activities as of today (including but not limited to nurses, public and private lab personnel, and others with direct contact with the public): workers in public health care settings who either work in situations where risk of transmission is high, who themselves are unable to avoid exposure to the virus, and who play a critical role in ensuring that those with or suspected of COVID-19 are able to be served by the public health system\*.

Enter "0" if the facility doesn't have these staff members.

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Setting(s) where this location will administer COVID-19 vaccine (select all that apply)\*

- ☐ Child care or day care facility
  - ☐ College, technical school, or university
  - ☐ Community center
  - ☐ Correctional/detention facility
  - ☐ Health care provider office, health center, medical practice, or outpatient clinic
  - ☐ Hospital (i.e., inpatient facility)
  - ☐ In home
  - ☐ Long-term care facility (e.g., nursing home, assisted living, independent living, skilled nursing)
  - ☐ Pharmacy
  - ☐ Public health clinic (e.g., local health department)
  - ☐ School (K – grade 12)
  - ☐ Shelter
  - ☐ Temporary or off-site vaccination clinic – point of dispensing (POD)
  - ☐ Temporary location – mobile clinic
  - ☐ Urgent care facility
  - ☐ Workplace
  - ☐ Other
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*Display This Question:*

*If Setting(s) where this location will administer COVID-19 vaccine (select all that apply)\* = Other*

Please specify "Other" for setting(s) where this location will administer COVID-19 vaccine\*.

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Population(s) served by this location (select all that apply)\*

- ☐ General pediatric population
- ☐ General adult population
- ☐ Adults 65 years of age and older
- ☐ Long-term care facility residents (nursing home, assisted living, or independent living facility)
- ☐ Health care workers
- ☐ Critical infrastructure/essential workers (e.g., education, law enforcement, food/agricultural workers, fire services)
- ☐ Military – active duty/reserves
- ☐ Military – veteran
- ☐ People experiencing homelessness
- ☐ Pregnant women
- ☐ Racial and ethnic minority groups
- ☐ Tribal communities
- ☐ People who are incarcerated/detained
- ☐ People living in rural communities
- ☐ People who are underinsured or uninsured
- ☐ People with disabilities
- ☐ People with underlying medical conditions\* that are risk factors for severe COVID-19 illness

☐

Other people at higher risk for COVID-19

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*Display This Question:*

*If Population(s) served by this location (select all that apply)\* = Other people at higher risk for COVID-19*

Please specify "Other people at higher risk for COVID-19":

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Does this provider serve the 0-18 years population?\*

☐ Yes (23)

☐ No (24)

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*Display This Question:*

*If Does this provider serve the 0-18 years population?\* = Yes*

Number of children 18 years of age and younger routinely served by this location\*. Enter UNK if you don't know.

We encourage you to provide at least an estimate. It will help CDC and the OSDH develop accurate COVID-19 vaccine allocation plans.

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Does this provider serve adults 19 – 64 years of age (doesn't include staff)?\*

☐ Yes (23)

☐ No (24)

*Display This Question:*

*If Does this provider serve adults 19 – 64 years of age (doesn't include staff)?\* = Yes*

Number of adults 19 – 64 years of age routinely served by this location\*. This number doesn't include staff. Enter UNK if you don't know.

We encourage you to provide at least an estimate. It will help CDC and the OSDH develop accurate COVID-19 vaccine allocation plans.

---

Does this provider serve adults 65 years of age and older (doesn't include staff)?\*

☐ Yes (1)

☐ No (2)

*Display This Question:*

*If Does this provider serve adults 65 years of age and older (doesn't include staff)?\* = Yes*

Number of adults 65 years of age and older routinely served by this location\*. This number doesn't include staff. Enter UNK if you don't know.

We encourage you to provide at least an estimate. It will help CDC and the OSDH develop accurate COVID-19 vaccine allocation plans.

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Number of unique patients/clients seen per week on average\*. This number doesn't include staff. Enter UNK if you don't know.

We encourage you to provide at least an estimate. It will help CDC and the OSDH develop accurate COVID-19 vaccine allocation plans.

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Are you currently an OSIIS user?\*

☐ Yes

☐ No

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*Display This Question:*

*If Are you currently an OSIIS user?\* = Yes*

Does your organization currently report vaccine administration data to the OSIIS?\*

☐ Yes

☐ No

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*Display This Question:*

*If Does your organization currently report vaccine administration data to the OSIIS?\* = No*

You answered your organization is not currently an OSIIS user or it does not currently report vaccine administration data to the OSIIS. Please explain planned method for reporting vaccine administration data to the OSIIS or other designated system as required\*.

Enter OSIIS if you plan to report data in OSIIS. Enter UNKNOWN if you don't know.

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*Display This Question:*

*If Are you currently an OSIIS user?\* = No*

Before you proceed with the enrollment, you must agree to the terms and conditions of the Oklahoma State Immunization Information System (OSIIS) Authorized Site Agreement below. This agreement ensures your facility can order, receive, and document the administration of pandemic vaccines in OSIIS. This allows CDC and the OSDH to accurately determine the number of immunizations which have been administered, a critical step in the control of a pandemic.

If state of Oklahoma decides to use another system to report vaccine administration data, we will notify you.

**Oklahoma State Immunization Information System (OSIIS)**  
**AUTHORIZED SITE AGREEMENT for Pandemic Providers**

The Oklahoma State Immunization Information System ("OSIIS") is a confidential, comprehensive database of immunizations administered to Oklahomans by participating providers. Access to OSIIS is granted only for the purposes of recording and/or verifying immunization requirements. This information is to be shared on an as needed basis only with school officials, public health officials, child care centers, other health care professionals or health institutions, the person's legal guardian, or other institutions required by law to collect immunization records. All records are considered confidential protected health information ("PHI") and are covered by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). All Authorized Sites and their users shall obtain and document authorization from the individual (or the individual's parent or legal guardian, if applicable) for the use and disclosure of protected health information unless the disclosure is for treatment, payment, or health care operations, or is otherwise permitted under applicable federal or state laws, rules, and/or regulations. All Authorized Sites and their users shall retain documentation of any such authorizations for at least six (6) years and shall produce copies to the Oklahoma Immunization Service upon request. The Oklahoma Immunization Service will periodically monitor and audit usage of OSIIS to ensure compliance with this Agreement, user agreements, the Confidentiality and Security Policy for OSIIS, and applicable federal and state law. The Oklahoma Immunization Service may terminate this Agreement and access to OSIIS at any time for any reason, including, but not limited to, a determination that the Authorized Site or any user has failed to comply with the terms and conditions of this Agreement.

The Authorized Site is responsible for providing any computer equipment and/or electronic communications necessary for use of OSIIS. The Authorized Site and its users shall implement appropriate administrative, technical, physical, and security safeguards in compliance with HIPAA that reasonably and appropriately safeguard and protect the confidentiality of PHI. Authorized Sites and users responsible for entering demographic and immunization information into OSIIS agree to do so in a timely manner.

The Authorized Site shall designate an OSIS Site Administrator to be responsible for use of OSIS by the Authorized Site and its users. The OSIS Site Administrator is responsible for:

- Authorizing and activating users and assigning user security within this site;
- Ensuring that each user has signed an OSIS User Agreement (each agreement will be kept on site by the OSIS Site Administrator and will be retained for at least six (6) years following the deactivation of the user's access);
- Providing oversight to ensure that users are timely deactivated when no longer affiliated with the Authorized Site;
- Ensuring that each user has his/her own user name and password;
- Notifying the Oklahoma Immunization Service of any changes to the Authorized Site's information, including, but not limited to, name, address, phone/number, site administrator, and closing of the Authorized Site;
- Ensuring compliance with the Confidentiality and Security Policy for OSIS; and
- Reporting to the Oklahoma Immunization Service any unauthorized use or disclosure of PHI or other material breach of this Agreement, the user agreements, or applicable law within 24 hours of discovery.

By clicking this box the Authorized Site, on behalf of itself and each of its users, attests and certifies that it has read, understood, and agrees to the terms and conditions presented in this Agreement.

Page Break

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*Display This Question:*

*If Are you currently an OSIS user?\* = Yes*

OSIS ID #\*

Your OSIS ID may be found by logging into your OSIS account. Enter OSIS ID, not Legacy ID! If you need help finding your OSIS ID, please email OSIShelp@health.ok.gov or call (405) 271-7200.

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Contact information for location's OSIIS Site Administrator\*:  
This person is/will be a point of contact for OSIIS.

☐ Last Name \_\_\_\_\_

☐ First Name \_\_\_\_\_

☐ Phone (format without extension 123-456-7890; format with extension 123-456-7890 x 12345) \_\_\_\_\_

☐ Email \_\_\_\_\_

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OSIIS has moved to a new system on 11/02/2020 called Enhanced OSIIS. Has your facility or someone from your facility attended an Enhanced OSIIS training session?\*

☐ Yes

☐ No

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Is this a Vaccines For Children (VFC) provider site?\*

☐ Yes

☐ No

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*Display This Question:*

*If Is this a Vaccines For Children (VFC) provider site?\* = Yes*

VFC PIN #\*

Your VFC PIN # is a 6-digit number; do not include OKA before 6 digits. If you don't know your VFC PIN #, please call (405) 271-4073 or email [immunize@health.ok.gov](mailto:immunize@health.ok.gov).

Number of influenza vaccine doses administered during the peak week of the 2019-20 influenza season (the week the clinic administered the most flu vaccines)\*. This number can include both

employees and patients/clients. Enter UNK if you don't know.

We encourage you to provide at least an estimate. This information will help CDC and the OSDH assess vaccination/throughput capacity.

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Maximum number of healthcare staff (dedicated vaccinators) available to administer COVID-19 vaccine on a given day\*:

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**Estimated number of 10-dose multidose vials (MDVs) your location is able to store at the following temperatures\*.**

- If your facility doesn't have a certain type of storage, enter "NO" for all columns.
- If a facility doesn't have any additional capacity during peak vaccination period, enter "0" for "Additional number of 10-dose multidose vials".
- If the equipment cannot meet the requirements of any of the temperature ranges listed, then it is not acceptable for storing COVID-19 vaccine and the answer should be "NO"



for all fields.

All fields must be filled in.

	Number of storage units at the following temperatures (5)	Volume (cubic feet) of storage units at the following temperatures. Example: if 2 freezers with 1.8cu ft and 5cu ft, then enter 6.8 (1.8 + 5). (4)	Maximum number of 10-dose multidose vials (MDVs) this facility is able to store. Example: if 2 freezers with 200 MDVs and 400 MDVs, then enter 600 (200 + 400). (1)	Additional number of 10-dose multidose vials (MDVs) during peak vaccination periods (e.g., during back-to-school or influenza season) this facility is able to store. Example: if facility's freezer is usually 90% full during peak vaccination periods, then enter how many MDVs the facility can store using the remaining 10% of the storage. (2)
Refrigerated (2°C to 8°C): (1)				
Frozen (-15°C to -25°C): (2)				
Ultra-frozen (-60°C to -80°C): (3)				

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List brand/model/type of storage units to be used for storing COVID-19 vaccine at this location\*.  
If a facility doesn't have any storage units, enter "NO" for #1, and leave #2-5 empty.

1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
- 

**Medical/pharmacy director or location's vaccine coordinator signature\*.**

I attest that each unit listed will maintain the appropriate temperature range indicated above  
(please sign):

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Today's Date\*:

\_\_\_\_\_

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Does this facility use a continuous monitoring thermometer?\*

☐ Yes

☐ No

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*Display This Question:*

*If Does this facility use a continuous monitoring thermometer?\* = Yes*

Type of continuous monitoring thermometer\*:

\_\_\_\_\_

*Display This Question:*

*If If False*

Cubic Feet of\*:

☐ Refrigerator \_\_\_\_\_

☐ Freezer \_\_\_\_\_

*Display This Question:*

*If If False*

Maximum available storage capacity (in doses)

\_\_\_\_\_

Please list licensed healthcare providers at this location who have **prescribing authority** (i.e., MD, DO, NP, PA, RPh). The list is limited to **25 providers.** You can list any 25 providers.

There is no need to email us additional providers. CDC will be using information only for 25 providers. Providers with prescribing authority who are not on this list and other providers licensed to administer vaccine will be able to administer COVID-19 vaccine.

	Provider Name (1)	Title (2)	License No. (3)
1 (1)			

(You will be able to add up to 25 providers)

**This is the last step in completing online COVID-19 Vaccination Program Provider enrollment for this facility: If you need to edit your responses, click "Back" button to go back to the question you want to edit.**

**You cannot edit your responses after you click "Submit" button. If you need to make edits after the submission, email to [Immunize@health.ok.gov](mailto:Immunize@health.ok.gov).**

**If your organization has more than one facility, each facility must complete this enrollment separately.**

**Please read before you click "Submit" button below:**

- After clicking "Submit" button, you will see your submitted responses. Download and Save them for future reference.
- The OSDH will receive your responses and Section A as soon as you click the "Submit" button below.
- The OSDH doesn't email confirmation of receipt.
- Please do not fax, mail, or email your responses or a signed paper copy of the "Section A" form to the OSDH.
- Only online enrollment will be accepted.
- Once approved by the OSDH, Primary and Back-up COVID-19 vaccine coordinators (you entered their contact information during the enrollment) will receive an email confirming facility's status as a COVID-19 vaccine provider. It may take a few days to process the enrollment during this busy time. Please be patient with us and keep

checking Primary and Back-up COVID-19 vaccine coordinators' emails regularly.

**Please click "Submit" button to complete this online enrollment.**