

VFC PROVIDER UPDATE FORM

Upon return of this form, a member of our Immunization staff will contact your facility to address, as needed, your specific needs.

NAME OF CLINIC (as it appears in OSIS): _____

☐ CHANGE CLINIC NAME TO: _____

Date of Request: ____/____/____ VFC PIN _____ OSIS ID _____

Staff Changes:

☐ New Primary VFC Coordinator

NAME: _____

E-MAIL _____

☐ New Secondary VFC Coordinator

NAME: _____

EMAIL _____

New Site Administrator _____

A Facility Authorization Request form is needed to add Site Administrators in OSIS

OFFICE RELOCATION/CHANGES

EFFECTIVE DATE: ____/____/____

NEW ADDRESS: _____

NEW PHONE NUMBER: (____) ____-____ NEW FAX NUMBER: (____) ____-____

CHANGES TO OFFICE SCHEDULE AND/OR DAYS AND TIMES WHEN VACCINE MAY BE DELIVERED:

Mon ____ Tues ____ Wed ____ Thur ____ Fri ____ Sat ____

WEEKLY OFFICE HOURS

Mon ____ Tues ____ Wed ____ Thur ____ Fri ____ Sat ____

OFFICE DELIVERY HOURS

IF THE OFFICE IS CLOSED FOR LUNCH, PLEASE SPECIFY THE EXACT TIME THE OFFICE IS CLOSED.

IF YES, WHEN? _____

☐ NEW REFRIGERATOR / FREEZER

☐ MOVING REFRIGERATOR / FREEZER

New or relocated vaccine storage units must be monitored by taking 5 days of temperatures prior to usage. Documentation of temperatures is required.

ADDITIONAL/NEW PROVIDER:

PROVIDER'S NAME	TITLE	MEDICAL LICENSE #	MEDICAID PROVIDER #
-----------------	-------	-------------------	---------------------

1. _____	_____	_____	_____
----------	-------	-------	-------

2. _____	_____	_____	_____
----------	-------	-------	-------

CHANGES TO YOUR CLIENT ENROLLMENT DATA, REQUIRE AN AMENDED PROVIDER PROFILE BE SUBMITTED

Please contact your Immunization Field Consultant or the VFC program with any questions.

Immunization Field Consultant (IFC):

Phone:

FAX:

Oklahoma State Dept of Health, VFC Program Immunization Division

PHONE: 405-271-4073

FAX: 405-271-6133

EMAIL: VFCHelp@health.ok.gov