

H1N1 Provider Registration Form

A. Facility Name: _____

Contact Name(s): _____

First MI Last Title

Vaccine Delivery and Storage Address: _____

Street Address (NO P.O. BOXES PLEASE)

City State Zip Code (+4 digit ext.)

Mailing Address: _____
(if different from above) Street Address and/or P.O. Box Number

City State Zip Code (+4 digit ext.)

Email Address: _____

Phone Number: () _____ **FAX Number:** () _____

Days/Times when you can receive vaccine deliveries (Indicate Days with "X"):

Monday _____ Times: _____

Tuesday _____ Times: _____

Wednesday _____ Times: _____

Thursday _____ Times: _____

Friday _____ Times: _____

B. Please estimate the number of individuals to be immunized at your practice/clinic for each of the following priority groups:

Pregnant women _____

Household and caregiver contacts of children younger than 6 months of age _____

Health care and emergency medical services personnel _____

Children from 6 months through 18 years _____

Persons aged 19-24 _____

Persons aged 25 through 64 years who have medical conditions associated with higher risk for flu-related complications _____

C. Storage equipment

Does your facility have vaccine storage equipment that will maintain a consistent temperature of 35 - 46°F? Yes _____ No _____

Does your facility have a certified thermometer for each refrigeration unit? Yes _____ No _____

D. Type of Vaccine Provider: (✓ one only)

- Public Health Department (10)
- Public Hospital (12)
- Federally Qualified Health Center or Rural Health Center (15)
- Private Hospital (22)
- Physician's Solo Practice (20)
- Other Public (16)
- Physician's Group Practice (20)
- Other Private (mass vaccination or retail companies) (24)

E. Practice Specialty:

- Pediatrics (Ped)
- Family Practice (FP)
- General Practice (GP)
- Internal Medicine (IM)
- Hospital (HOSP)
- Multi-Specialty (Mult)
- YDC
- Not Applicable – mass vaccination or retail setting