

# 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 OSIIS): \_\_\_\_\_

CHANGE CLINIC NAME TO: \_\_\_\_\_

Date of Request: \_\_\_\_/\_\_\_\_/\_\_\_\_ VFC PIN \_\_\_\_\_ OSIIS 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 OSIIS

## 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 #
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1. _____	_____	_____	_____
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2. _____	_____	_____	_____
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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: 405-426-8580

FAX: 405-900-7612

EMAIL: [VFCHelp@health.ok.gov](mailto:VFCHelp@health.ok.gov)