

# 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: \_\_\_\_\_

**New Secondary VFC Coordinator**  
NAME: \_\_\_\_\_

E-MAIL \_\_\_\_\_

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 DAYS AND TIMES WHEN VACCINE MAY BE DELIVERED:

Mon \_\_\_\_ Tues \_\_\_\_ Wed \_\_\_\_ Thur \_\_\_\_ Fri \_\_\_\_ Sat \_\_\_\_

**IS THE OFFICE CLOSED FOR LUNCH? YES NO      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**