2020/2021 Vermont Vaccine Program (VVP) Off-Site & School Located Clinic
Addendum Provider Agreement

This addendum to administer state-supplied influenza or Covid19 vaccine in an off-site, community or school located vaccine clinic (SLVC) must be completed annually by a currently enrolled VVP practice.

Practice Name: _______________________________________________ PIN# __________

Name of off-site clinic coordinator (staff member who will be present at the clinics):

______________________________________________________________________________

Coordinator email and phone number: __________________________________________

What type of clinic do you plan to conduct?

☐ School Located Vaccine Clinic
   List school name(s) and town____________________________________________________

☐ Off-Site Community Clinic (migrant workers, homeless shelters, syringe exchange, etc.)
   List clinic type, site, and town__________________________________________________

Population Served

☐ Pediatric patients (0-18)  

☐ Adult patients (19+)

Vaccines to be offered

Vaccines offered at the school located clinic:

☐ Influenza  ☐ COVID19 (when available)

The clinic coordinator will be contacted by the Immunization Program to provide specific information about planned locations, dates, and anticipated vaccine doses needed.
PROVIDER AGREEMENT

To receive publicly funded vaccines at no cost for the purposes of a SLVC or other off-site community clinic, I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the health care facility of which I am the medical director or equivalent:

1. I will follow the provider agreement signed as part of the VCVP/VAVP enrollment form.

2. I will communicate any changes to the Vermont Vaccine Program (VVP) in a timely manner.

3. I understand this practice or the Vermont Vaccine Program may terminate this agreement at any time. If I choose to terminate this agreement, I will properly return any unused federal vaccine as directed by the Vermont Immunization Program.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, that I have read and agree to the provider agreement enrollment requirements listed in the VCVP/VAVP enrollment as they apply to SLVC and other off-site/community clinics and understand I am accountable for compliance with these requirements.

Medical Director or equivalent (print):

Signature: ___________________________ Date: ____________

This record is to be submitted email or fax and kept on file at the Vermont Department of Health Immunization Program.

Ahs.vdhimmunizationprogram@vermont.gov
VERMONT DEPARTMENT OF HEALTH IMMUNIZATION PROGRAM
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FAX 802-863-7395