VERMONT
DEPARTMENT OF HEALTH

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.

Vermont Vaccine Program – Phone (802) 863-7638 – Email ahs.vdhimmunizationprogram@vermont.gov

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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
PHONE 802-863-7638
FAX 802-863-7395