

Arizona Novel H1N1 Influenza Vaccine Distribution Program 2009-2010

Pre-Registration Form

All Arizona healthcare providers interested in participating in the novel H1N1 Influenza Vaccine Distribution Program must complete this form and fax it to 602-364-3232. Alternately, electronic pre-registration submission is available at <http://www.azdhs.gov/flu/h1n1/index.htm> Pre-registration information will be used to estimate vaccine needs and establish a shipping address. Providers are not committed to receive vaccine by completing this form. When the vaccine becomes available for distribution, providers will receive a provider agreement and order form that must be returned to ADHS in order to receive vaccine. **Submit only one pre-registration form per practice site. Call (602) 364-3895 for further questions.**

A. Practice Name:

B. Contact:

Last Name	First Name	Title	Backline Phone Number
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C. E-mail Address:

D. Vaccine delivery street address:

E. Delivery city, zip and county:

F. Mailing Address:

Street or PO Box	City	Zip	County
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G. Phone #'s:	Area Code:	Main:	Fax:
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H. Hours/Days when office is open: Closed for Lunch? Yes No

I. Do you have a high-speed internet connection? Yes No Hours closed for lunch:

J. Classification of Practice: Please choose one from the list below

- Private Practice, Individual or Group
- Hospital
- Other Private Facility
- County Health Department
- Community Health Center (FQHC)
- Rural Health Center (RHC)
- Other Public Facility (IHS, Tribal, Fire, etc.)

Type of Practice: Please choose one from the list below

- Family/General Hospital
- Pediatrics Pharmacy
- Other Specialty: _____
- County Health Department OB/GYN
- Indian Health Service (IHS/Tribal Health Center)
- FQHC/RHC School Based Clinic
- Other Public Specialty: _____

K. This Section Must Be Completed: If you need help, call Arizona Immunization Program Office at (602) 364-3895

Estimate number of patients and staff by target group for whom you plan to order novel H1N1 vaccine

Children 6 months through 18 years of age	
Young adults 19-24 years of age	
Pregnant women	
Adults living with or caring for children under 6 months of age	
Health Care Workers and Emergency Services Personnel	
Chronic Health Conditions 25-64 years of age	
All Other Patients	
Total	

Please sign, print your name, add the date and then return by fax to Arizona Immunization Program Office at 602-364-3232

Signature of Authorizing MD, DO, RNP, PA, or Pharmacist Only	Printed Name	Date
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A physician (MD, DO), RNP, PA, or Pharmacist must sign all forms. An RN, LPN, or MA cannot sign the forms.

