



Arizona Vaccines for Adults (VFA) Program

VFA PIN: _____

Provider Profile

October 2015 - September 2018

A. Practice Name:			
B. VFA Contact:			
Last Name, First Name		Title	Backline Ph #
C. E-mail Address:			
D. Vaccine delivery <u>street</u> address:			
E. Delivery city, zip and County:			
F. Mailing Address:			
Street or PO Box		City	Zip County
G. Phone#'s:	Area Code:	Main:	Fax:
H. Days when office is open:			Closed for Lunch? Y __ N __
I. Hours when office is open:			Hours closed for lunch:
J. Classification of Practice: Please choose one from the list below <input type="checkbox"/> Public Health Department - (11) <input type="checkbox"/> Fed Qualified Health Center/Rural Health Clinic - (15) <input type="checkbox"/> Other Public Health - (17): _____ <input type="checkbox"/> Private Practice, Individual or Group - (21) <input type="checkbox"/> Private Hospital - (23) <input type="checkbox"/> Private Other - (25)		Type of Practice: Please choose one from the list below <input type="checkbox"/> Community Health Center <input type="checkbox"/> Family Health Center <input type="checkbox"/> Indian Health Services <input type="checkbox"/> County Health Department <input type="checkbox"/> Family/General (primary care) <input type="checkbox"/> STD clinic <input type="checkbox"/> Jail <input type="checkbox"/> Syringe Exchange program <input type="checkbox"/> HIV C&T <input type="checkbox"/> Prison <input type="checkbox"/> Substance abuse <input type="checkbox"/> Other: _____	
K. Approximate the total client visits that will be seen at this site from October 2015 - September 2016 for:			
Number of Uninsured Adults: _____		Number of Underinsured Adults: _____	
If you agree with the above information, please sign, and print your name. Return with other completed documents to the Arizona Immunization Program Office.			
Signature		Printed Name	Date
<i>A physician or equivalent must sign all forms.</i>			