

State of Connecticut-Department of Public Health
H1N1 Provider Profile
Enrollment Form

PIN: _____
(Office Use Only)

All health care providers who receive H1N1 vaccine from the Connecticut Department of Public Health Immunization Program must complete this form. This document provides shipping information, hours of operation for each office and will help to determine the amount of vaccine to be supplied. The Immunization Program will keep this record on file with the SIGNED "Provider Agreement". **Complete one form for each office/site/satellite.**

Practice Information/Shipping				Practice Mailing Address			
Name:							
Vaccine Delivery/Shipping Address (Cannot be a P.O. Box):				Mailing Address:			
Street Address:				Mailing Address, Part 2:			
City:		Zip:		City:		Zip:	
Contact Person*:		Phone Number*:		Office Phone:		Office Fax:	
* If possible, we would like the contact name and direct phone number for the person who orders the vaccine.				Federal Employer Tax ID Number:			
Provider Type: <input type="checkbox"/> College/University <input type="checkbox"/> Federal Qualified Health Center/ rural health <input type="checkbox"/> Hospital <input type="checkbox"/> Public Health Department <input type="checkbox"/> School/School Based Hlth Ctr				Specialty or 'Specialty Clinic' Type: <input type="checkbox"/> Internal medicine <input type="checkbox"/> Family practice <input type="checkbox"/> Family planning <input type="checkbox"/> LTCF/Nursing Home <input type="checkbox"/> Multi-specialty <input type="checkbox"/> OB/Gyn			
<input type="checkbox"/> Private practice (individual or group) <input type="checkbox"/> Other public (please specify): _____ <input type="checkbox"/> Other private (please specify): _____				<input type="checkbox"/> Pediatrics <input type="checkbox"/> Pharmacy <input type="checkbox"/> VNA <input type="checkbox"/> Walk-in center <input type="checkbox"/> Other (please specify): _____			
Hours of Operation (Please specify if the office is closed for lunch and cannot receive a vaccine delivery during that time)							
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
Provider Personnel							
Please provide the following information for all personnel who administer vaccines. If additional room is needed please attach a separate sheet of paper.							
Physician				CT License #		Medicaid Billing #	
Physician				CT License #		Medicaid Billing #	
Physician				CT License #		Medicaid Billing #	
RN, APRN				CT License #		Medicaid Billing #	
Other				CT License #		Medicaid Billing #	
Patient Estimates							
How much seasonal influenza vaccine did your practice/facility order and administer in the 2008-09 flu season?				Estimate the number of patients expected to need H1N1 vaccine:			
No. of doses ordered:		Total doses administered:		6 mo – 18 yrs**	19-24 yrs**	25-64 yrs**	>65 yrs**
_____		_____		_____	_____	_____	_____
				**These numbers must be entered in order to receive vaccines.			
E-Mail Communication							
In the future, we may use e-mail for some communications; please provide the e-mail address for your facility:							

PLEASE REMEMBER TO SIGN THE ACCOMPANYING "PROVIDER AGREEMENT".

Return to:
State of Connecticut, Department of Public Health
410 Capitol Avenue, M.S.# 11MUN, Hartford, CT 06134-0308
Phone: 860-509-7929
Fax: 860-509-8371

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