Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., Secretary

2025 Maryland Vaccines For Children (VFC) Program Online Enrollment

Note: Questions marked with an asterisk (*) are mandatory.

As part of the federal regulations governing the Maryland VFC Program, VFC providers are required to enroll in the VFC Program annually.

Please complete the following survey to enroll in the Maryland VFC Program for 2025. Please review the hard copy of the survey and the Suggested Immunization Schedule Using Combination Vaccines at www.Marylandvfc.org prior to beginning the online survey.

The survey has the following elements:

1. VFC Provider Practice/Facility Information
2. Responsible Medical Provider Information
3. Practice/Facility Vaccine Primary Supply Contact Information
4. VFC Provider Enrollment Agreement
5. Additional Medical Providers within the Practice
6. Vaccine Preferences
7. Operation Hours
8. Programmatic Questions
9. VFC Provider Satisfaction

Vaccine brand preferences will remain in effect for 2025. Requests to change your vaccine preferences will require a written justification to the VFC program.

FAILURE TO COMPLETE THE ONLINE ENROLLMENT PROCESS BY DECEMBER 31, 2024 WILL RESULT IN DIS-ENROLLMENT FROM THE VFC PROGRAM.

Section 1: VFC PROVIDER PRACTICE/FACILITY INFORMATION

Complete the enrollment survey for every VFC PIN where vaccines are shipped.

* **Type of Practice/Facility**

* **Sub Type**

Family Medicine
Internal Medicine
OB/GYN
Other Specialty
Pediatrics

Note: If you have a change in your Org Type or Org Sub-Type or Practice/Facility Address, please contact the VFC Contact Center at mdh.izinfo@maryland.gov.

Federal guidelines require the collection of patient data in order to improve VFC vaccine accountability. This information will be used to properly determine the correct amount of VFC vaccine to supply your practice/facility. Please provide the following patient estimates based on the previous 12 months or estimates for the upcoming 12 months if past year's data is not available.

* Total number of Maryland Medicaid children (0 - 18 yrs of age) assigned to your practice/facility.

* Total number of Insured (private pay/health insurance covers vaccines) children (0 - 18 yrs) seen at your facility.

* Practice/Facility Address Line 1

Practice/Facility Address Line 2

* City

* State

MD

* ZIP

* County

* Practice/Facility Phone Number

* Alternate Phone Number

* Practice/Facility FAX Number

Mailing Address (if different from Practice/Facility Address)

Address Line 1

Address Line 2

City

State

MD

ZIP

County

Vaccine Shipping Address (If Different From Practice/Facility Address)

Check the box to populate fields using Section 1, Practice/Facility Information
(Note: If there will be a change in shipping or clinic address, providers must notify VFC before relocation.)

* **Address Line 1 (No PO Box)**

Address Line 2

* **City**

* **State**

MD

* **Zip**

* **County**

* **Phone Number**

* **Alternate Phone Number**

* **Fax Number**

Section 2: RESPONSIBLE MEDICAL PROVIDER INFORMATION

The official VFC registered health care provider signing the agreement must be a practitioner authorized to administer pediatric vaccines under Maryland law, who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlined in the provider enrollment agreement. The individual listed here must sign the provider agreement and complete the required annual VFC trainings.

* **Medical License Number**

Enter the full Medical License Number, including any leading zeros.

* **First Name**

* **Last Name**

* **Credentials (e.g. MD, DO, NP, PA, Pharm.)**

* **Title**

* **Employer Identification Number**

* **Medicaid Provider Number**

* **Telephone Number**

* **FAX Number**

* **Email Address (must be different from Vaccine Supply Contact) - limited to 35 characters**

*Certificate of VFC Training

Note: Acceptable file formats are PDF, JPG, and PNG (no special characters in file title- #,!,% etc.).
Upload certificate(s) for the RMP in this section only

Section 3a: PRACTICE/FACILITY VACCINE SUPPLY PRIMARY CONTACT INFORMATION

(Must be different from Responsible Medical Provider)

* First Name

* Last Name

* Office Position

* Telephone Number

* FAX Number

* Email Address (All emails must be unique) - limited to 35 characters

NOTE: Please check your Spam/Junk folder for email verification link.

*Certificate of VFC Training

Note: Acceptable file formats are PDF, JPG, and PNG (no special characters in file title- #,!,% etc.).
Upload certificate(s) for the Vaccine Primary Contact in this section only.

Section 3b: PRACTICE/FACILITY VACCINE SUPPLY 1st BACKUP CONTACT INFORMATION

(Must be different from Vaccine Supply Primary Contact)

* First Name

* Last Name

* Office Position

* Phone Number

* FAX Number

* Email Address (All emails must be unique) - limited to 35 characters

*Certificate of VFC Training

Note: Acceptable file formats are PDF, JPG, and PNG (no special characters in file title- #,!,% etc.). Upload certificate(s) for the Vaccine Supply 1st Backup in this section only.

Section 3c: PRACTICE/FACILITY VACCINE SUPPLY 2nd BACKUP CONTACT INFORMATION (OPTIONAL)

NOTE: If data is entered into any fields in this section, all fields will be required including the Certificate of VFC Training.

(Must be different from Vaccine Supply Primary Contact)

First Name

Last Name

Office Position

Phone Number

Fax Number

Email Address (All emails must be unique) - limited to 35 characters

Certificate of VFC Training

Note: Acceptable file formats are PDF, JPG, and PNG (no special characters in file title- #,!,% etc.). Upload certificate(s) for the Vaccine Supply 2nd Backup in this section only.

Section 4: VFC PROVIDER ENROLLMENT AGREEMENT

To receive publicly funded vaccines at no cost (vaccine is defined as any FDA-authorized or licensed, ACIP-recommended product for which ACIP approves a VFC resolution for inclusion in the VFC program), I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the healthcare facility of which I am the medical director or practice administrator or equivalent:

*** 1. I will annually submit a provider profile when requested (e.g., MCO panels, uninsured logs, doses administered reports) representing populations served by my practice/facility. I will notify Maryland VFC if:**

1. **the number of children served significantly changes or**
2. **the status of the facility changes during the calendar year.**

◯ * I acknowledge.

*** 2. I will screen patients and document eligibility status at each immunization encounter for VFC eligibility and administer VFC-purchased vaccine by such category only to children who are 18 years of age or younger who meet one or more of the following category: Federally Vaccine-eligible Children (VFC eligible)**

1. **are an American Indian or Alaska Native;**
2. **are enrolled in Medicaid;**
3. **have no health insurance;**
4. **are underinsured: (a) A child who has health insurance, but the coverage does not include vaccines; (b) A child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only). Underinsured children are eligible to receive VFC vaccine only through a Federally Qualified Health Center (FQHC), or Rural Health Clinic (RHC) or Maryland Local Health Department; (c) Health insurance has a fixed dollar limit or cap for vaccines (child is VFC eligible once fixed dollar limit or cap amount is reached).**

Children aged 0 through 18 years that do not meet one or more of the VFC eligibility federal vaccine categories, are NOT ELIGIBLE to receive VFC-purchased vaccines

◯ * I acknowledge.

*** 3. I will administer vaccines (routine and non-routine) and comply with immunization schedules, dosages, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP) and included in the VFC program unless:**

a. In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate for the individual child; or
b. The particular requirements contradict state law, including laws pertaining to religious exemptions.

◯ * I acknowledge.

*** 4. I will maintain all records related to the VFC program for a minimum of three years and upon request make these records available for review. VFC records include, but are not limited to, VFC screening and eligibility documentation, billing records, medical records that verify receipt of vaccine, vaccine ordering records, private vaccine purchase, accountability records, and temperature monitoring records including DDL data.**

◯ * I acknowledge.

* **5. I will vaccinate eligible children with publicly supplied vaccines at no charge to the patient for the vaccine.**

◯ * I acknowledge.

* **6. I will not charge a vaccine administration fee to non-Medicaid federal vaccine eligible children that exceeds the administration fee cap of $23.28 per vaccine dose. For Medicaid children, I will accept the reimbursement for immunization administration set by the state Medicaid agency or the contracted Medicaid health plans.**

◯ * I acknowledge.

* **7. I will not deny administration of a publicly purchased vaccine to an established patient because the child's parent/guardian/individual of record is unable to pay the administration fee. If I choose to bill for the vaccine administration fee of a non-Medicaid, VFC-eligible child after the date of service I will issue only a single bill to the patient within 90 days of vaccine administration. I will not submit unpaid administration fees to collections.**

◯ * I acknowledge.

* **8. I will distribute the most current Vaccine Information Statements (VIS) before each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA), which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS). Provide patients with an Immunization Information Statement (as opposed to a Vaccine Information Statement [VIS]) prior to administration of Nirsevimab (RSV). Report adverse events following administration of Nirsevimab (RSV) to MedWatch, unless co-administered with a vaccine. If a COVID-19 Vaccine Information Statement (VIS) is not available, providers should provide information prior to vaccination as follows: EUA Fact Sheet for Recipients, Emergency Use Instructions (EUI), or BLA package insert, as applicable.**

◯ * I acknowledge.

* **9. I will comply with the requirements for vaccine management including:**
  a. **Ordering vaccine and maintaining appropriate vaccine inventories;**
  b. **Store vaccine in a stand alone storage unit and/or a pharmaceutical grade storage unit;**
  c. **Not store vaccine in dormitory-style units at any time;**
  d. **Store vaccines under proper storage conditions at all times. Refrigerator and freezer vaccine storage units and temperature monitoring equipment and practices must meet Maryland MDH VFC Program storage and handling recommendations and requirements;**
  e. **Providers must keep on hand or have ready access to the supplies needed for emergency transport such as a Hard-sided insulated containers, Styrofoam, or portable vaccine refrigerator/freezer units (preferred option), Coolant materials such as phase change materials (PCMs) or frozen water bottles that can be conditioned to 4° C to 5° C, Insulating materials such as bubble wrap and corrugated cardboard—enough to form two layers per container and Temperature-monitoring devices for each container;**
  f. **Return all spoiled/expired public vaccines to CDC's centralized vaccine distributor within six months of spoilage/expiration;**
  g. **Not borrowing/loaning VFC supplied vaccine without prior approval.**

◯ * I acknowledge.

* **10. I agree to operate within the VFC program in a manner intended to avoid fraud and abuse. Consistent with "fraud" and "abuse" as defined in the Medicaid regulations at 42 CFR § 455.2, and**

for the purposes of the VFC Program:

Fraud: is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse: provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, (and/or including actions that result in an unnecessary cost to the immunization program, a health insurance company, or a patient); or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

◯ * I acknowledge.

* **11. I will participate in VFC program compliance site visits including unannounced visits, and other annual educational and training opportunities associated with VFC program requirements, as directed.**

◯ * I acknowledge.

* **12. FOR LOCAL HEALTH DEPARTMENTS (LHDs) ONLY:**
For Local Health Departments with a signed deputization Memorandum of Understanding between a FQHC and the Maryland MDH VFC Program to serve underinsured VFC-eligible children, I agree to:

a. **Include "underinsured" as a VFC eligibility category during the screening for VFC eligibility at every visit;**
b. **Vaccinate "walk-in" VFC-eligible underinsured children;**
c. **Report required usage data; and**
d. **Not deny administration of a publicly purchased vaccine because the child's parent/guardian/individual of record is unable to pay the administration fee. If I choose to bill for the vaccine administration fee of a non-Medicaid, VFC-eligible child after the date of service, I will issue only a single bill to the patient within 90 days of vaccine administration. I will not submit unpaid administration fees to collections.**

Note: ***"Walk-in" in this context refers to any underinsured child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve underinsured patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to underinsured patients as well. "Walk-in" may also include VFC-eligible newborn infants at a birthing facility.***

***Choose One:**

◯ * I acknowledge.

◯ * I am not a local health department.

* 13. **FOR PHARMACIES, URGENT CARE, OR SCHOOL LOCATED VACCINE CLINICS ONLY:**
For pharmacies, urgent care, or school located vaccine clinics, I agree to:

a. **Vaccinate all "walk-in" VFC-eligible children and**
b. **Will not refuse to vaccinate VFC-eligible children based on a parent's inability to pay the administration fee. If I choose to bill for the vaccine administration fee of a non-Medicaid, VFC-eligible child after the date of service, I will issue only a single bill to the patient within 90 days of vaccine administration. I will not submit unpaid administration fees to collections.**

Note: ***"Walk-in" refers to any VFC eligible child who presents requesting a vaccine; not just established patients. "Walk-in" does not mean that a provider must serve VFC patients without an appointment. If a provider's office policy is for all patients to make an appointment to receive immunizations then the policy would apply to VFC patients as well. "Walk-in" may also include VFC-eligible newborn infants at a birthing facility.***

***Choose One:**

◯ * I acknowledge.

◯ * I am not a pharmacy, urgent care, or school located vaccine clinic.

* 14. **I agree to replace VFC vaccines purchased with federal funds that are deemed non-viable due to provider negligence on a DOSE-FOR-DOSE basis.**

◯ * I acknowledge.

* 15. **I will report to the Maryland Immunization Information System (ImmuNet) all doses of vaccines administered to children less than 19 years of age within seven (7) calendar days.**

◯ * I acknowledge.

* 16. **I will enter my VFC vaccine inventory into ImmuNet so that VFC vaccines may be ordered for my practice. With my inventory I will submit the most current two (2) months of DDL data for all the storage units used for VFC vaccines.**

◯ * I acknowledge.

* 17. **I agree to use a Digital Data Logger (DDL) for my vaccine storage units as well as an available back-up DDL that meets Maryland VFC requirements.**

Note: I will also respond to all DDL temperature excursions and alarms. If vaccines need to be transported to our backup facility, I will comply with VFC requirements on emergency transport of vaccines including temperature monitoring during transport and while the vaccines are in the backup facility or storage unit/s.

◯ * I acknowledge.

* 18. **I understand this facility or the Maryland VFC 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 Maryland MDH VFC Program.

◯ * I acknowledge

BY ENTERING MY NAME BELOW, I CERTIFY ON BEHALF OF MYSELF AND ALL IMMUNIZATION PROVIDERS IN THIS FACILITY, I HAVE READ AND AGREE TO THE VACCINES FOR CHILDREN ENROLLMENT REQUIREMENTS LISTED ABOVE AND UNDERSTAND THAT I AM ACCOUNTABLE (AND EACH LISTED PROVIDER IS INDIVIDUALLY ACCOUNTABLE) FOR COMPLIANCE WITH THESE REQUIREMENTS.

* **Responsible Medical Provider Name**

* **Date (MM/DD/YYYY)**

Section 5: ADDITIONAL MEDICAL PROVIDERS WITHIN THE PRACTICE (OPTIONAL)

Please enter the names and medical license numbers of the other health providers who may administer VFC vaccines. It is not necessary to include the names of all staff who may administer vaccines, only those who possess a medical license or are authorized to write prescriptions.

PROVIDER - I

First Name

Last Name

Email – limit to 35 characters

Medical License Number

Credentials (e.g. MD, DO, NP, PA, Pharm.)

Medicaid Provider Number

PROVIDER - II

First Name

Last Name

Email – limit to 35 characters

Medical License Number

Credentials (e.g. MD, DO, NP, PA, Pharm.)

Medicaid Provider Number

More Medical Provider Entries

- ◯ Yes (if yes, additional provider slots will open)
- ◯ No

Section 6: VACCINE PREFERENCES

NOTE: The vaccines that you select will supersede any vaccine brand selections currently on file.

The VFC Program will attempt to honor all vaccine requests, however the VFC Program reserves the right to ship vaccines based on VFC Program need or vaccine supply. MMR, Polio, Varicella and HPV are produced by a single manufacturer. After consultation with legal counsel, the Maryland Department of Health (MDH) determined that minors may consent to receipt of the hepatitis B vaccine (HBV) and human papillomavirus (HPV) vaccination because they are preventive treatment for a venereal disease. Please review the Suggested Immunization Schedule Using Combination Vaccines at www.Marylandvfc.org before completing this section.

* **DTaP**

Note: Select "Not Applicable" if you are an OB/GYN or only serve adolescent patients.

- Infanrix (GSK) Pre-filled Syringes
- DAPTACEL (Sanofi) Vials
- Not Applicable

* Combination DTaP

Note: Providers selecting a combination DTaP vaccine are expected to administer the ACIP recommended number of doses. Pediarix and Vaxelis will be sent in quantities for all 3 recommended doses. Pentacel will be sent in quantities for all 4 recommended doses.
Select "Not Applicable" if you are an OB/GYN or only serve adolescent patients.

- Pediarix (GSK) Pre-filled Syringes
- Pentacel (Sanofi) Vials
- Vaxelis (Merck) Pre-filled Syringes
- Not Applicable

* DTaP-Polio

Note: DTaP-Polio is an optional use vaccine.
Select "Not Applicable" if you do not want to use DTaP-Polio in your office.

- Kinrix (GSK) Pre-filled Syringes
- Quadracel (Sanofi) Vials
- Quadracel (Sanofi) Pre-filled Syringes
- Not Applicable

* MMRV

Note: ProQuad is an optional use vaccine.
Select "ProQuad for kids 12+months and 4 years" if you want to use ProQuad for children 1 year of age and older.
Select "ProQuad1 for kids 4+yo" if you only want to use ProQuad for patients 4 years of age and older.
Select "Not Applicable" if you do not want to use ProQuad in your office.

- ProQuad for Kids 12+months and 4 years
- ProQuad1 for Kids 4+yo
- Not Applicable

* HIB

Note: Select "Not Applicable" if you are an OB/GYN or only serve adolescent patients.

- ActHIB (Sanofi) Vials
- PedvaxHib (Merck) Vials
- Hiberix (GSK) Vials
- Not Applicable

* Hepatitis B

Note: Select "Not Applicable" if you are an OB/GYN that does not administer Hep B.

- Engerix (GSK) Pre-filled Syringes
- Recombivax (Merck) Syringes
- Not Applicable

* Tdap

Note: Select "Not Applicable" if you are an OB/GYN that does not administer Tdap.
Note: Tdap is required for 7th-12th graders.

- Adacel (Sanofi) Vials
- Adacel (Sanofi) Pre-filled Syringes
- Boostrix (GSK) Pre-filled Syringes
- Not Applicable

* Hepatitis A

Note: Select "Not Applicable" if you are an OB/GYN that does not administer Hepatitis A.

- Havrix (GSK) Pre-filled Syringes
- Vaqta (Merck) Pre-filled Syringes
- Not Applicable

* Meningococcal

Note: Select "Not Applicable" if you are an OB/GYN that does not administer MCV4.
Note: Meningococcal B Vaccine (Bexsero and Trumenba) are special order vaccines through ImmuNet.
Note: Meningococcal vaccination is required for 7th-12th graders.

- Menveo (GSK) Vials
- Menquadfi (Sanofi) Vials
- Not Applicable

* Rotavirus

Note: Select "Not Applicable" if you are an OB/GYN or only serve adolescent patients.

- Rotarix (GSK) Oral
- Rotateq (Merck) Oral
- Not Applicable

* **MMR**

Note: Select "Not Applicable" if you are an OB/GYN that does not administer MMR.

- MMR II (Merck) Vials
- Priorix (GSK) Vials
- Not Applicable

* **PCV**

Note: Select "Not Applicable" if you are an OB/GYN that does not administer PCV.

- Prevnar (Pfizer) Pre-filled syringes
- Vaxneuvance (Merck) Pre-filled syringes
- Not Applicable

* **HPV**

Note: Select "Not Applicable" if your practice does not serve adolescent patients.

- Gardasil 9 (Merck) Pre-filled Syringes
- Not Applicable

* **Polio**

Note: Select "Not Applicable" if you are an OB/GYN that does not administer Polio.

- IPOL (Sanofi) Vials
- Not Applicable

* **Varicella**

Note: Select "Not Applicable" if you are an OB/GYN that does not administer Varicella.

- Varivax (Merck) Vials
- Not Applicable

* **COVID-19 Pediatric**

Note: Select "Not Applicable" if you are an OB/GYN that does not administer COVID-19.

- Moderna Syringe (6 mo - 11 y)
- Pfizer Vials (6 months - 4 years) & (5 years - 11 years)
- Not Applicable

* **COVID-19 Adolescent**

Note: Select "Not Applicable" if you are an OB/GYN that does not administer COVID-19.

- Moderna Syringe (12 years - 18 years)
- Novavax Vials (12 years - 18 years)
- Pfizer Vials (12 years - 18 years)

- Not Applicable

This is your opportunity to select your vaccine brand preferences. Your preferences will remain in effect for 2025 . If you wish to change these preferences you must submit a written justification on practice letterhead and signed by the responsible medical provider to the Maryland VFC Program.

◯ * Acknowledge **We acknowledge that the Vaccine Preferences were reviewed and understand that any changes made will be automatically applied. Any errors that are made will need to be rectified manually by filling out the change form on the VFC website.**

Section 7: OPERATION HOURS

***Office Hours (when office is open and when it closes):**

Monday: _____ **to** _____ ☐ **Closed**

Tuesday: _____ **to** _____ ☐ **Closed**

Wednesday: _____ **to** _____ ☐ **Closed**

Thursday: _____ **to** _____ ☐ **Closed**

Friday: _____ **to** _____ ☐ **Closed**

Saturday: _____ **to** _____ ☐ **Closed**

Sunday: _____ **to** _____ ☐ **Closed**

***Delivery Window (timeframe when shipment should arrive):**

*** Delivery Window #1**	**Delivery Window #2**
Monday: _____ **to** _____	**Monday:** _____ **to** _____
Tuesday: _____ **to** _____	**Tuesday:** _____ **to** _____
Wednesday: _____ **to** _____	**Wednesday:** _____ **to** _____
Thursday: _____ **to** _____	**Thursday:** _____ **to** _____
Friday: _____ **to** _____	**Friday:** _____ **to** _____
Saturday: _____ **to** _____	**Saturday:** _____ **to** _____
Sunday: _____ **to** _____	**Sunday:** _____ **to** _____

Note: Delivery window must be between 8AM and 7pm with a required minimum of 4-hour block of time.

Section 8: PROGRAMMATIC QUESTIONS

* **1. Digital data loggers (DDLs) are required to monitor temperatures of your VFC vaccine storage units. Please refer to the VFC thermometer description for DDL requirements.**

* **Does your practice have DDLs for your VFC Vaccine Storage Units?**

- Choose One: ◯ Yes ◯ No

If your DDL unit has a dual probe (one unit to record both refrigerator and freezer temperatures), please enter the same information for DDL #1 and DDL #2.

*DDL 1 Make

*DDL 1 Model

*DDL 1 Serial #

*DDL 1 Calibration Expiration Date

*Does your DDL have a double probe? ◯ Yes ◯ No

*DDL 2 Make

*DDL 2 Model

*DDL 2 Serial #

*DDL 2 Calibration Expiration Date

*Does your DDL have a double probe? ◯ Yes ◯ No

*Backup Make

*Backup Model

*Backup Serial #

*Backup Calibration Expiration Date

*Does your DDL have a double probe? ◯ Yes ◯ No

Note: A backup DDL must be readily available in case a DDL fails or calibration testing is required. The backup DDL should have a different calibration retesting date than other DDLs to avoid requiring all DDLs to be sent out for recalibration at the same time. If the backup DDL has the same calibration retesting date, providers must have the unit retested prior to expiration, ensuring that a valid DDL is available for required temperature monitoring. According to the CDC, backup DDLs should not be utilized at the same time as your primary DDLs in the storage unit. This can result in conflicting temperature readings between the backup and main DDLs, which can lead to potential confusion.

DDL 3 Make

DDL 3 Model

DDL 3 Serial #

DDL 3 Calibration Date

Does your DDL have a double probe? ◯ Yes ◯ No

More DDL entries:

◯ Yes (if Yes, additional DDL slots will open)

◯ No

* **2. What type of storage unit(s) does your facility have to store VFC vaccines (check all that apply)? Please add make and serial numbers for each type of unit.**

(Note: If practice is replacing any vaccine storage unit, VFC must be notified and approved before use.)

- Refrigerator (Stand Alone and/or Pharmaceutical Grade)

*Vaccine Storage Unit 1 Make & Model

*Vaccine Storage Unit 1 Serial Number

Vaccine Storage Unit 2 Make & Model

Vaccine Storage Unit 2 Serial Number

More Vaccine Storage Unit Entries? ◯ Yes ◯ No

- Freezer (Stand Alone and/or Pharmaceutical Grade)

*Vaccine Storage Unit 1 Make & Model

*Vaccine Storage Unit 1 Serial Number

Vaccine Storage Unit 2 Make & Model

Vaccine Storage Unit 2 Serial Number

More Vaccine Storage Unit Entries? ◯ Yes ◯ No

- Pharmaceutical Grade combination unit

* Vaccine Storage Unit 1 Make & Model

* Vaccine Storage Unit 1 Serial Number

Vaccine Storage Unit 2 Make & Model

Vaccine Storage Unit 2 Serial Number

More Vaccine Storage Unit Entries? ○ Yes ○ No

- Dorm Style (single exterior door and an evaporator plate/cooling coil in a freezer compartment)

*Vaccine Storage Unit 1 Make & Model

*Vaccine Storage Unit 1 Serial Number

Vaccine Storage Unit 2 Make & Model

Vaccine Storage Unit 2 Serial Number

More Vaccine Storage Unit Entries? ○ Yes ○ No

Note: Dorm style units are not allowed for the storage of VFC vaccines.

* **3. Please indicate the vaccine storage and handling practices your office follows: (please select all that apply)**

- ○ "Do Not Unplug" signs placed on the refrigerator, circuit breaker and on the electrical outlet.
- ○ Vaccines with the most current expiration dates are used first.
- ○ Refrigerator and freezer temperatures checked and manually recorded at least twice daily.
- ○ Current and valid certified calibrated Digital Data Loggers (DDL) used to review temperatures.
- ○ Minimum and maximum temperatures are assessed and recorded at the start of each clinic day from the DDL.

  The minimum and maximum temperatures for the last 24 hours are reviewed and recorded each morning and then reset. If your DDL automatically resets at 12AM, then you will need to manually review the previous 24 hours for min/max temperatures.
- ○ Vaccines never stored on the doors of a refrigerator or in the bottom bins.
- ○ Vaccines organized based on type of vaccine
- ○ Food and drinks are not kept in the same unit with vaccines.
- ○ Ice packs are kept in the freezer and defrosted ice packs or water bottles in the refrigerator.
- ○ Vaccine doses are NOT drawn up until ready for administration.
- ○ VFC vaccines are kept separately from privately purchased vaccines.
- ○ VFC vaccine is never borrowed without prior approval from VFC.

* **4. Please describe in detail (how, who, when) the procedures taken when VFC vaccine is delivered.**

*** 5. Please describe your practice's procedures that will be taken if a temperature excursion occurs in your vaccine storage unit/s.**

*** 6. What is your Vaccine Emergency Relocation Plan: Identify another practice, hospital or other location to move vaccines in times of disaster. One back-up location is mandatory and two locations are recommended. (A staff member or other person's home is not an acceptable relocation). VFC may request DDL data from your backup location for review where VFC vaccines are temporarily stored. Enter the other facility/org name, complete address and phone number.**

* 7. **Does your facility have 24/7 notification or alerts from a DDL company if temperature excursions occur after business hours including weekends and holidays?**

***Choose One:** ◯ Yes ◯ No

*** If yes, please describe your protocol on your response to alerts after business hours.**

*** 8. What supplies do you have for emergency transport of vaccines to a backup facility? (please select all that apply)**

- ○ Portable vaccine refrigerator/freezer units (preferred option)
- ○ Hard-sided insulated containers or Styrofoam
- ○ Coolant materials such as phase change materials (PCMs) or frozen water bottles that can be conditioned to 4° C to 5° C
- ○ Insulating materials such as bubble wrap and corrugated cardboard—enough to form two layers per container
- ○ DDL for each container

***9. Please indicate the expired/wastage vaccine practices your office follows: (select all that applies)**

- ○ Expired and wasted vaccine is accounted for and returned to the VFC program.
- ○ In the event of vaccine loss, a vaccine manufacturer report regarding the viability of the vaccine is sent to VFC.
- ○ In the event of vaccine loss, a VFC Vaccine Return and Wastage form should be completed on the

MarylandVFC.org website.

* **10. According to Maryland VFC Policy, do you make accessible all NON-ROUTINE VFC-recommended vaccines (e.g. Meningococcal B, PPV23) for those VFC patients who meet the criteria for receiving them?**

*** Choose One:** ◯ Yes ◯ No

***If no, why not:**

IMMUNET QUESTIONS

* **11. Does your office have at least two (2) active ImmuNet (Maryland Immunization Registry) users?**

*** Choose One:** ◯ Yes ◯ No

If yes, **note that Admin users can grant new users access to ImmuNet**.

If no, please click on this link to register for ImmuNet access.

*** 12. Please list the name of your electronic health/medical record (EHR/EMR) system:**

If you do not have an EHR/EMR, please complete the ImmuNet Manual Data Agreement form. Ensure that all patient vaccination records are entered within 7 days (VFC Agreement #15).

* **13. Name of person completing this survey:**

Section 9: VFC Provider Satisfaction

*** 1. Overall, how satisfied are you with the Maryland VFC Program:**

- ○ Very Satisfied
- ○ Somewhat Satisfied
- ○ Neutral
- ○ Somewhat Dissatisfied
- ○ Very Dissatisfied

*** 2. Overall, how satisfied are you with the email communication sent by VFC?**

- ○ Very Satisfied
- ○ Somewhat Satisfied

- ○ Neutral
- ○ Somewhat Dissatisfied
- ○ Very Dissatisfied

***3. Overall, how satisfied are you with ease of compliance with Maryland VFC Program requirements (i.e., vaccine storage and handling, vaccine ordering, VFC site visits):**

- ○ Very Satisfied
- ○ Somewhat Satisfied
- ○ Neutral
- ○ Somewhat Dissatisfied
- ○ Very Dissatisfied

*** 4. Overall, how satisfied are you with the new VFC website (MarylandVFC.org)?**

- ○ Very Satisfied
- ○ Somewhat Satisfied
- ○ Neutral
- ○ Somewhat Dissatisfied
- ○ Very Dissatisfied

*** 5. Would you recommend participation with the VFC program with other non-VFC providers?**

- ○ Yes
- ○ No

***6. What suggestions do you have to improve the VFC program?**

***7. Overall, how satisfied are you with the Maryland VFC programming training options (i.e., stand-alone training module, webinar training)?**

- ○ Very Satisfied
- ○ Somewhat Satisfied
- ○ Neutral
- ○ Somewhat Dissatisfied
- ○ Very Dissatisfied

***8. Have you participated in and completed IQIP Visits (First Visit, 2-month Call, 6-month Call, 12-month Visit) at some point in the last 4 years?**

- ○ Yes (if yes, answer below and question 9)

- ○ No

Have you noticed improvements in your assessment reports from ImmuNet after implementation of core strategies selected?

- ○ Yes
- ○ No
- ○ Don't know. We have not pulled our organization reports from ImmuNet

***9. Overall, how satisfied are you IQIP Visits?**

- ○ Very Satisfied
- ○ Somewhat Satisfied
- ○ Neutral
- ○ Not Satisfied
- ○ Very Dissatisfied

***10. What suggestions do you have to improve IQIP?**

***11. Please suggest any recommendations for improvement for the Maryland VFC program:**