DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

VFC – Provider Change of Information Request Form

This form is provided to alert the VFC Program when facilities experience change that impacts the program, i.e. staffing or other changes. Upon receipt of this FAX Back, Immunization staff will contact your facility to arrange for a visit (if necessary) to address your specific needs. Please check the type of change(s) that occurred:

- ☐ New immunization staff
- ☐ New Staff Name _____
- ☐ New VFC contact
- ☐ Refrigerator – Moved **(Refrigerator unplugged)**
- ☐ New Physician/Nurse Practitioner*
- ☐ Clinic/Office closing
- ☐ Clinic/Office relocated
- ☐ new address and phone number for clinic _____
- ☐ Remove VFC contact _____
- ☐ New refrigerator or freezer **(Must be validated prior to storing VFC vaccine)**
- ☐ New Shipping Hours
- ☐ Other _____

Name of Clinic_____PIN # _____

Address _____

Name's of VFC Contact (Primary): _____
(Must have two)
(Secondary):_____

VFC Contact E-mail address _____ _____
(Primary) (Secondary)

Telephone No._____Fax No. _____

Other Type of Contact: _____

☐ **Please check if this is a new address.**

Change Effective Date: _____

*Physician/NP Name	Title	Medical License #	Medicaid Provider #

Will this change your client enrollment data?_____if yes, please amend your Provider Profile.

_____

Print Name of Medical Director Signature of Medical Director Date

Please fax this form to the DC VFC Program, 202.541.5906

899 North Capitol Street, NE, 3rd Floor, Washington, D.C. 20002 (202) 576-9319, (202) 541-5906 (Fax)

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