**New Jersey Department of Health and Senior Services**
**Vaccine Preventable Disease Program**
**PO Box 369**
**Trenton, NJ 08625**

**FORM 2**
**PROVIDER ENROLLMENT**
**American Recovery and Reinvestment Act Vaccines**
**FAX NUMBER (609) 826-4868**

A Name of Facility/Practice: _____

B. Name of Lead Physician: _____

C. Medical License Number: _____

Type of Physician (MD, DO, etc.): _____

D. In order to participate in the American Recovery and Reinvestment Act Vaccine Program which will provide certain vaccines to me at no cost, I, on behalf of myself and any and all practitioners, nurses, and others associated with this medical office, group practice, managed care organization, health department, community/migrant/rural clinic, or other entity of which I am the physician-in-chief or equivalent, agree to the following:

1. I will immunize persons with American Recovery and Reinvestment Act Vaccines at no charge to the patient for the vaccine(s).
2. I will use the New Jersey Immunization System (NJIIS) to account for every vaccination, to maintain temperature logs and to report vaccine inventory. I will ensure NJIIS is continuously updated to account for my vaccine usage and inventory.
3. I agree to enter all vaccine administration records into NJIIS to account for all vaccine received, prior to re-ordering vaccine.
4. I will fax or call in my NJVFC ARRA vaccine order request.
5. I understand this program requires zero percent vaccine wastage, expiration or spoilage for any reason and should I exceed this amount, my facility will be terminated from the program without option of re-enrollment.
6. I will not charge more than the administration fee cap of $ 16.35
7. I will comply with the appropriate immunization schedule, dosage, and contraindications, that are established by the CDC Advisory Committee on Immunization Practices (ACIP) unless (a) in making a medical judgment in accordance with accepted medical practice, I deem such compliance to be medically inappropriate or (b) the particular recommendation is not in compliance with the laws of my State, including state laws relating to religious or other exemptions.
8. I will provide the most current Vaccine Information Statement (VIS) for each vaccination given and will maintain records in accordance with the National Childhood Vaccine Injury Act.
9. I will report clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
10. Upon request, I will make all records pertaining to the American Recovery and Reinvestment Act Vaccine Program available to the State or the U.S. Department of Health and Human Services for site visit/audit purposes.
11. I or the State may terminate this agreement at any time for any reason. I agree to return all unviable and unused viable vaccine to the NJVFC program in accordance with the instructions provided to me and I understand that I may be required to replace dose for dose any vaccine lost due to mismanagement within my practice.

Lead Physician Signature: _____ Date: _____ - _____ - _____