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

FORM 1
PROVIDER PROFILE
American Recovery and Reinvestment Act Vaccines
FAX NUMBER (609) 826-4868

A. National Provider Identifier (NPI): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Current NJVFC Provider? Circle one: Yes No NJVFC PIN: _____

B. Name of Facility/Practice:

_____

C. Name of Lead Physician:

_____

D. Name of Contact Person: _____ Title: _____

E. Vaccine Delivery Address (No PO Boxes) Street:

_____

Suite/Floor: _____ City: _____ NJ Zip: _____

F. Telephone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ ext. _____

FAX: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Email: _____

G. Office Hours When Vaccine Can Be Delivered **note if closed for lunch**):

M _____T _____W _____

TH _____F _____

H. Type of Facility (check one):

[ ] Public Health Department
[ ] Private Physician's Office (Individual or Group)
[ ] Federally Qualified Health Center (FQHC)
[ ] Not for Profit Hospital
[ ] For Profit Hospital
[ ] Retail Setting
[ ] Other Immunization Projects
[ ] Home Health Agency for Profit
[ ] Home Health Agency Not for Profit

I. Estimate the number of persons requesting vaccination at your facility in the coming year:

Less than 19 years old: _____ Adults 19 years old and up: _____

I verify the above information to be correct and true to the best of my knowledge:

Signature of Lead Physician: _____Date: _____ - _____ - _____