

Process to Complete the CDC COVID-19 Provider Agreement in NJIIS

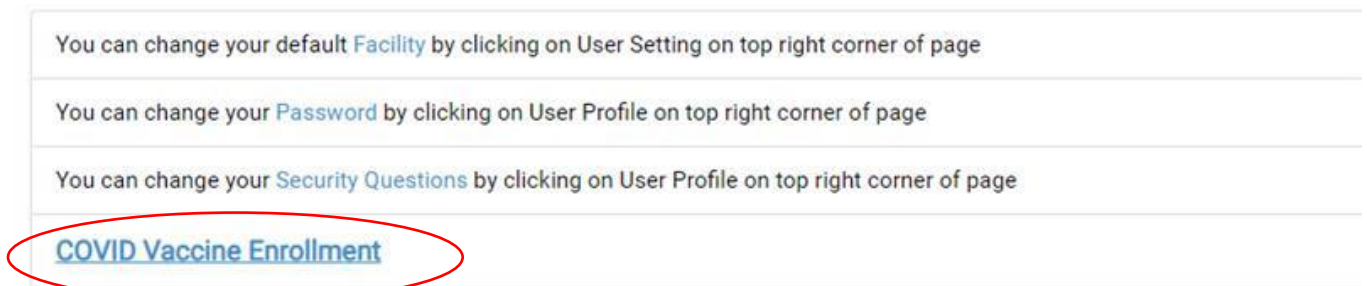
Please note, in order to be able to enroll your facility as a COVID-19 provider, you must have access to NJIIS already. If your facility has never been established in NJIIS please complete the New Facility Enrollment at the following link: <https://njiis.nj.gov/covid/web/index.html#/newFacilityEnrollment>

Also, if your facility needs to create additional users in NJIIS that have not yet been trained but will play a role in your COVID-19 vaccination response, you can use the COVID-19 User Enrollment Guide.

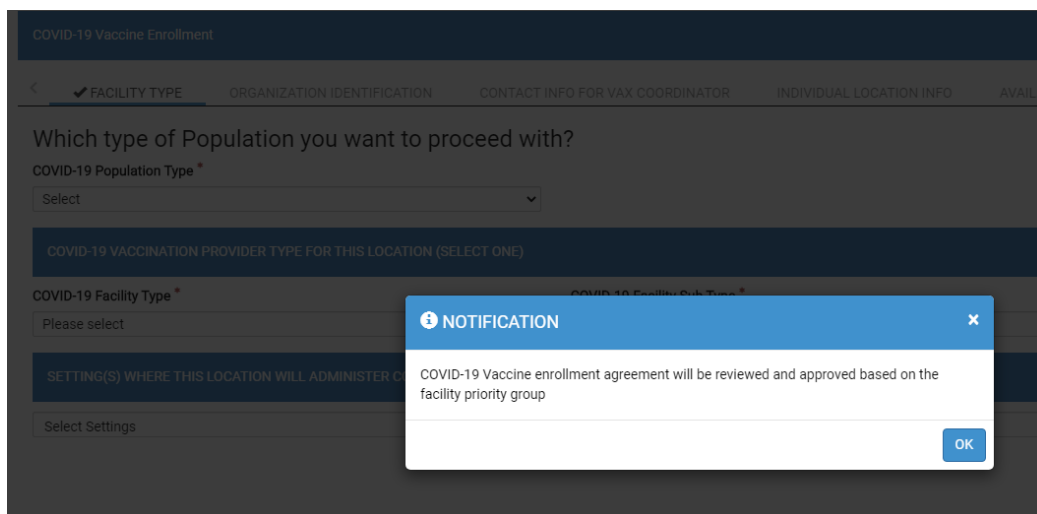
Finally, some facilities that are already enrolled with NJIIS and provide both VFC and 317 vaccines should complete the Provider Agreement under the facility ID associated with their 317 PIN. You can order both Adult and Pediatric vaccines using the 317 PIN.

NJ COVID-19 Provider Enrollment Module

1. Login to NJIIS
2. Click on COVID Vaccine Enrollment



3. Complete the Provider Agreement and submit (the following screens will take you through the Provider Agreement Process step by step).



4. This is the first screen in NJIIS but please note this information is found on Page 5 of the PDF version of the Provider Agreement (known as “PDF Agreement” as we move forward). When selecting COVID-19 Population Type, if your facility sees both adults and children, select Adult and Pediatric. Additionally, please select how you plan to submit COVID-19 immunization data to NJIIS. Additional information on the EHR interface and Excel upload can be found here: <https://njiis.nj.gov/core/web/index.html#/newFacilityEnrollment>

COVID-19 Vaccine Enrollment

< **FACILITY TYPE** ORGANIZATION IDENTIFICATION CONTACT INFO FOR VAX COORDINATOR INDIVIDUAL LOCATION INFO AVAILABILITY FOR VACCINE SHIPMENTS PATIENT POPULATION STORAGE CAPACI >

Which type of Population you want to proceed with?

COVID-19 Population Type *

Select

COVID-19 VACCINATION PROVIDER TYPE FOR THIS LOCATION (SELECT ONE)

COVID-19 Facility Type * COVID-19 Facility Sub Type *

Please select Please select

SETTING(S) WHERE THIS LOCATION WILL ADMINISTER COVID-19 VACCINE (SELECT ALL THAT APPLY) *

Select Settings

DATA SUBMISSION

How do you plan on submitting your immunization data to NJIIS? *

Select

Please select an option.

Next Reset

- This is Section A of the Provider Agreement. This information is found on Page 1 of the PDF Agreement. Please note that the individual listed as the Chief Medical Officer must be a New Jersey licensed MD or DO (or RPh for pharmacy only).

COVID-19 Vaccine Enrollment

< FACILITY TYPE ORGANIZATION IDENTIFICATION CONTACT INFO FOR VAX COORDINATOR INDIVIDUAL LOCATION INFO AVAILABILITY FOR VACCINE SHIPMENTS PATIENT POPULATION STORAGE CAPA >

ORGANIZATION IDENTIFICATION

Enter information about your organization as indicated.
 The "Organization" that will be the responsible party for COVID-19 vaccination efforts taking place in any of the facilities that are a part of that "Organization".
 An "Organization" may have many sites that fall under its jurisdiction where COVID-19 vaccine will be given, these various sites would have to individually be called facilities.

Organization's Legal Name *

Organization Telephone Number *

Email *

Work Email - 40 characters
(must be monitored and will serve as dedicated contact method for the COVID-19 Vaccination Program)

Address Line 1 *

Address Line 2

City *

State *

Zip *

County

Municipality

RESPONSIBLE OFFICERS

For the purposes of this COVID-19 Vaccination Enrollment, in addition to Organization, Responsible Officers named below will also be accountable for compliance with conditions specified in the Agreement. The individuals must provide their signatures after reviewing the Agreement requirements.

Chief Medical Office(or Equivalent) Information

Last Name * **First Name *** **Middle Name**

Title *

Licensure (State) *

Licensure (Number) *

Phone *

Email *

Address Line 1 *

Address Line 2

City *

State *

Zip *

County

Municipality

Chief Executive Office(or Chief Fiduciary) Information

Last Name * **First Name *** **Middle Name**

Phone *

Email *

Address Line 1 *

Address Line 2

City *

State *

Zip *

County

Municipality

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6. Here you will choose your Primary and Backup COVID-19 Vaccine Coordinators. This information can be found on page 4 of the PDF Agreement. The individuals that will be named as your facility's Coordinators must already be NJIS users and associated with your facility. If you get to this page and do not see your coordinators' names in the drop downs, please see the COVID-19 User Enrollment Guide in order to register those users, you will not be able to proceed past this tab until they are enrolled.

COVID-19 Vaccine Enrollment

< ✓ FACILITY TYPE ✓ ORGANIZATION IDENTIFICATION CONTACT INFO FOR VAX COORDINATOR INDIVIDUAL LOCATION INFO AVAILABILITY FOR VACCINE SHIPMENTS PATIENT POPULATION STORAGE CAPA >

Designate 2 onsite staff as Vaccine Coordinators. These positions will be responsible for some key requirements and will provide oversight for all vaccine management within the office. These people are responsible for being the points of contact for receiving vaccine shipments, monitoring storage unit temperatures, managing vaccine inventory, etc. The people designated should be physically located at the site.

Vaccine Coordinators must complete COVID-19 Enrollment Training

Primary COVID-19 Coordinator * Backup COVID-19 Coordinator *

Please select Please select

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7. This is in Section B of the agreement, each facility that will be receiving and providing COVID-19 vaccine will need to have this section filled out, even if they are covered by the CMO and CEO/CFO by an organization in Part A of the PDF Agreement.
 - a. This also includes any PODs that your organization may want to stand up that will be providing vaccine on more than 1 day.
 - b. If your organization is **not** planning on having vaccine shipped to all sites but will be transporting vaccine to alternative sites to be stored (i.e. stored overnight and not returned to the originating storage site after use at a clinic) you will need to complete Redistribution Agreements. Given the challenges with maintaining the cold chain, the relocation of vaccine should not be routinely considered and is subject to DOH approval.

COVID-19 Vaccine Enrollment

< ✓ FACILITY TYPE ✓ ORGANIZATION IDENTIFICATION ✓ CONTACT INFO FOR VAX COORDINATOR INDIVIDUAL LOCATION INFO AVAILABILITY FOR VACCINE SHIPMENTS PATIENT POPULATION STORAGE >

Office Information

Office Name
COVID AGREEMENT

Tax ID NPI Number Medicaid Number

10 Digits 7 Digits

ORGANIZATION LOCATION ADDRESS FOR RECEIPT OF COVID-19 VACCINE SHIPMENTS

Address Line 1 * Address Line 2

STREET ADDRESS SECONDARY ADDRESS

City * State * Zip * County * Municipality * Phone * Ext.

CITY NEW JERSEY 5 digits zip or h Select County Select Municipality () - - - - Max 5 Digits

Fax * Office Email *

() - - - - Work Email - 40 characters

(This email address will be used for all correspondences from the Program to your office)

ORGANIZATION ADDRESS OF LOCATION WHERE COVID-19 VACCINE WILL BE ADMINISTERED (IF DIFFERENT FROM RECEIVING LOCATION)

Address Line 1 Address Line 2

STREET ADDRESS SECONDARY ADDRESS

City State Zip County Municipality Phone Ext.

CITY Select State 5 digits zip or h Select County Select Municipality () - - - - Max 5 Digits

Fax

() - - - -

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8. The information below corresponds to page 4 of the PDF Agreement.
 - a. You must enter the times for each day that vaccine shipment will be accepted for receipt at the facility referenced in the previous screen.
 - b. Please enter times in a 24hr format. For example, if your facility is willing to receive vaccine from 9am-5pm please enter on the first line 09:00 to 12:00 and on the second line 12:00 to 17:00.

COVID-19 Vaccine Enrollment

<
✓ FACILITY TYPE
✓ ORGANIZATION IDENTIFICATION
✓ CONTACT INFO FOR VAX COORDINATOR
✓ INDIVIDUAL LOCATION IN

Vaccine Delivery Hours

Office hours when vaccine shipment can be delivered (Exclude lunch hours if office is closed):

<input type="checkbox"/> Mo	<input type="checkbox"/> Tu	<input type="checkbox"/> W	<input type="checkbox"/> TH	<input type="checkbox"/> F
From: <input type="text" value=""/> :hh <input type="text" value=""/> :mm			To: <input type="text" value=""/> :hh <input type="text" value=""/> :mm	And
From: <input type="text" value=""/> :hh <input type="text" value=""/> :mm			To: <input type="text" value=""/> :hh <input type="text" value=""/> :mm	

<input type="checkbox"/> Mo	<input type="checkbox"/> Tu	<input type="checkbox"/> W	<input type="checkbox"/> TH	<input type="checkbox"/> F
From: <input type="text" value=""/> :hh <input type="text" value=""/> :mm			To: <input type="text" value=""/> :hh <input type="text" value=""/> :mm	And
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From: <input type="text" value=""/> :hh <input type="text" value=""/> :mm			To: <input type="text" value=""/> :hh <input type="text" value=""/> :mm	

<input type="checkbox"/> Mo	<input type="checkbox"/> Tu	<input type="checkbox"/> W	<input type="checkbox"/> TH	<input type="checkbox"/> F
From: <input type="text" value=""/> :hh <input type="text" value=""/> :mm			To: <input type="text" value=""/> :hh <input type="text" value=""/> :mm	And
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<input type="checkbox"/> Mo	<input type="checkbox"/> Tu	<input type="checkbox"/> W	<input type="checkbox"/> TH	<input type="checkbox"/> F
From: <input type="text" value=""/> :hh <input type="text" value=""/> :mm			To: <input type="text" value=""/> :hh <input type="text" value=""/> :mm	And
From: <input type="text" value=""/> :hh <input type="text" value=""/> :mm			To: <input type="text" value=""/> :hh <input type="text" value=""/> :mm	

Special Delivery Instruction

Shipping Instruction

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9. This information can be found on pages 5 and 6 of the PDF Agreement. These numbers are meant to approximate the number of unique patients your facility serves in a 12-month period.
- You can find the number per week by adding all the categories and dividing by 52.
 - You can approximate the number of influenza vaccine administered by looking at the highest volume week from the previous influenza season.
 - If you do not know your IIS identifier, you can look at the top of the page at your facility's information and it should be listed there. Again, please note that if your facility provides both VFC and 317 vaccines, you should be completing the agreement under the NJIIS Facility ID that is associated with your 317 PIN.

COVID-19 Vaccine Enrollment

< ✓ FACILITY TYPE ✓ ORGANIZATION IDENTIFICATION ✓ CONTACT INFO FOR VAX COORDINATOR ✓ INDIVIDUAL LOCATION INFO ✓ AVAILABILITY FOR VACCINE SHIPMENTS
PATIENT POPULATION
STOR/ >

APPROXIMATE NUMBER OF PATIENTS/CLIENTS ROUTINELY SERVED BY THIS LOCATION

Number of children 18 years of age and younger * (Enter "0" if the location does not serve this age group)

Unknown

Number of adults 19-64 years of age * (Enter "0" if the location does not serve this age group)

Unknown

Number of adults 65 years of age and older * (Enter "0" if the location does not serve this age group)

Unknown

Number of unique patients/clients seen per week, on average *

Unknown

Not applicable (e.g. for commercial vaccination service providers)

INFLUENZA VACCINATION CAPACITY FOR THIS LOCATION

Number of influenza vaccines doses administered during the peak week of the 2019-20 influenza season *

(Enter "0" if the location does not serve this age group)

INFLUENZA VACCINATION CAPACITY FOR THIS LOCATION

Number of influenza vaccines doses administered during the peak week of the 2019-20 influenza season *

Unknown

POPULATION(S) SERVED BY THIS LOCATION (SELECT ALL THAT APPLY) *

Select Population Served ▼

* <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-increased-risk.html>

DOES YOUR ORGANIZATION CURRENTLY REPORT VACCINE ADMINISTRATION DATA TO THE STATE, LOCAL OR TERRITORIAL IMMUNIZATION INFORMATION SYSTEM(IIS)?

Yes - List IIS Identifier

No

Not Applicable

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10. Next you will have to submit each of your Digital Data Logger's (DDL) Certificates of Calibration. Please note that you will need one DDL for each storage unit you plan to store vaccine in, and one backup DDL at your facility for transport, or in case a DDL malfunctions or needs to be sent out for calibration. Select whether the unit is a primary or backup, the number of probes on your DDL (one vs. two) and list the serial/certification number and expiration date of the certificate of calibration. Then click the "add" button.

You will see the DDL added to the list below. Click "Upload" on the right side of the line and upload the Certificate of Calibration by clicking "Choose File". Then click "upload". File types that are acceptable include .png, .jpg, .jpeg, .gif, or PDF.

COVID-19 Vaccine Enrollment

< ✓ PATIENT POPULATION ✓ THERMOMETER REQUIREMENTS ✓ STORAGE CAPACITY ✓ PROVIDERS PRACTICING AT FACILITY ✓ SIGNATURES ✓ REVIEW >

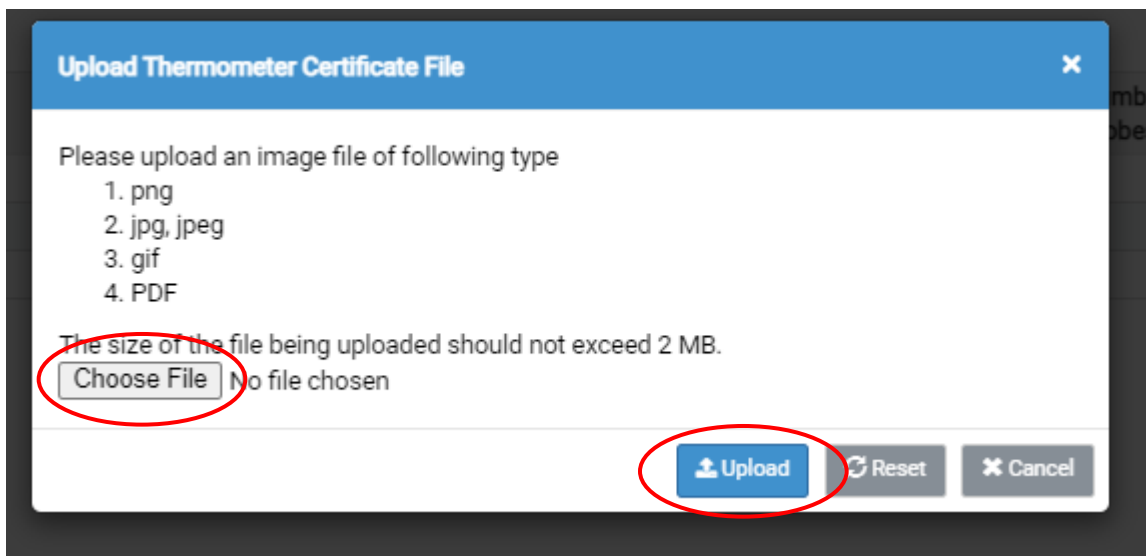
Each vaccine storage unit must have a continuous monitoring thermometer (data logger) which meets at least the following criteria:

- Digital temperature display outside storage unit
- Detachable probe in a buffered material
- Alarm
- Current and minimum and maximum temperatures
- Accuracy within +/-1°F (+/- .5°C)
- Low battery indicator
- Measures current and daily minimum and maximum temperatures in the unit
- Memory for storing at least 4,000 readings
- Programmable logging interval (recommended to be set for 30 minute intervals)

The CDC REQUIRES thermometers with continuous monitoring and recording capabilities (data loggers) to record temperatures over time.
Enter only one certification number for each thermometer regardless of the number of probes.

Category * Type * Number of Probes * Certification or Serial Number: * NIST Expiration Date: *

Select category Select Type Select Alpha Numeric Only MM/DD/YYYY + Add ✕ Cancel



11. This information is found on page 6 of the PDF Agreement. Please put what your storage capacity would be if you plan on receiving COVID-19 vaccine.
- For example, if your ultra-cold freezer is currently full, would you be able to shift items out of that unit to facilitate storage of COVID-19 vaccine, and if so, how many 10-dose multidose vials would be able to be stored.
 - Also, please add all the storage units you have available at your facility and include the brand, model and type.
 - Finally have your Medical or Pharmacy director's information available and input below.

COVID-19 Vaccine Enrollment

ORGANIZATION IDENTIFICATION
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ESTIMATED NUMBER OF 10-DOSE MULTIDOSE VIALS (MDVs) YOUR LOCATION IS ABLE TO STORE DURING PEAK VACCINATION PERIODS (E.G., DURING BACK-TO-SCHOOL OR INFLUENZA VACCINE SEASON) AT THE FOLLOWING TEMPERATURES

Refrigerated(2°C to 8°C)*	<input type="radio"/> No capacity	<input type="radio"/> Approximately	<input type="text" value="Number only"/>	additional 10-dose MDVs
Frozen(-15°C to -25°C)*	<input type="radio"/> No capacity	<input type="radio"/> Approximately	<input type="text" value="Number only"/>	additional 10-dose MDVs
Ultra-frozen(-60°C to -80°C)*	<input type="radio"/> No capacity	<input type="radio"/> Approximately	<input type="text" value="Number only"/>	additional 10-dose MDVs

STORAGE UNIT DETAILS FOR THIS LOCATION

Brand*
 Model*
 Type*

MEDICAL/PHARMACY DIRECTOR OR LOCATION'S VACCINE COORDINATOR SIGNATURE

I attest that each unit listed will maintain the appropriate temperature range indicated above: (please sign and date)

Medical/pharmacy director or location's vaccine coordinator signature*
 Date*

Please type in full Medical Director's name without punctuation

12. This information is found on page 7 of the PDF Agreement. Please add each of the individuals at your facility that will be involved in prescribing, ordering or writing a standing order for COVID-19 vaccine.
- This does not need be an exhaustive list of every provider at your facility.
 - You will need to provide the Medical License Number for each of the providers you list.

COVID-19 Vaccine Enrollment

ACT INFO FOR VAX COORDINATOR
 INDIVIDUAL LOCATION INFO
 AVAILABILITY FOR VACCINE SHIPMENTS
 PATIENT POPULATION
 STORAGE CAPACITY
 PROVIDERS PRACTICING AT FACILITY
 SIGNATURE >

Prescribing Providers at this Facility

List all licensed healthcare providers at this location who would be involved in prescribing or ordering COVID-19 vaccines.

Title*	Last Name*	First Name*	Middle Name
<input type="text" value="Select"/>	<input type="text" value="LAST NAME"/>	<input type="text" value="FIRST NAME"/>	<input type="text" value="MIDDLE NAME"/>
DOB	NPI Number	Medical License Number*	
<input type="text" value="MM/DD/YYYY"/>	<input type="text" value="10 Digits"/>	<input type="text" value="21 Digits"/>	

13. This information is found on page 3 of the PDF Agreement. You will need to assure that the dates that you input in the fields on this tab match the dates when your CMO and CEO signed.
 - a. To download the COVID-19 Vaccination Program Provider Agreement signature pages, click on “Click Here” circled below.
 - b. Upload the document signed by the CMO and CEO by clicking on “Choose File”. Please ensure the signatures match the CMO and CEO listed earlier in the Provider Agreement. Your application will be rejected if the signatures do not correspond to the same CMO and CEO.
 - c. You can choose to upload a full copy of the Provider Agreement or you can simply submit the signature pages (pages 2-3 of the PDF Agreement). You may upload a .png, .jpg/.jpeg or a .PDF file on this tab.

14. Once you have submitted all the required information in the module you will be asked to review and assure all the information is correct.
 - a. You can toggle back through the tabs and make changes at this point.
 - b. Once you are confident that the information is correct, you may want to print a copy for your records at this time, and then you may hit Submit.
 - c. This will generate a form number; you may want to record your form number for reference if you have any questions.
 - d. You may also leave comments in the field below.

Your data will save as you complete each tab, as long as you submit the tab (hit “Next” once all the information is filled in) it will retain its data and you may return later to complete the remainder of the agreement. We appreciate your assistance with this vaccination effort.

If you have any issues while completing your provider agreement, please send an email to COVID19.Provider@doh.nj.gov. Please note your facility name and facility NJIS ID in the subject line.