



Birth Dose Hospital

VFC Provider Enrollment Agreement

These directions are intended to provide step-by-step instructions for completing the Vaccines for Children (VFC) Program's annual re-enrollment, which is required for all participating VFC providers.

1. Click on the "VFC RE-ENROLLMENT FORMS":

NESIS
Nebraska State
Immunization
Information System

Production Region 8.1.0

Maintenance
manage physicians
manage sites
manage clinicians
manage schools
vfc re-enrollment forms

home manage access/account forms related links logout help desk training

organization IR Physicians • user Ernad Klipic • role VFC Administrator

announcements:
Currently, there are no announcements.

release notes:
NEW 01/19/2017 ~ [Release Version 8.1.0](#) Release 8.1.0
[more release notes](#)

2. Please review all information in this section to confirm that it is correct. If there is any information that is inaccurate, please click on the "Edit VFC Profile" button above to make any necessary corrections. Then, in the dropdown list under "Organization Type", select **BIRTH DOSE HOSPITAL**:

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organization IR Physicians • user Ernad Klipic • role VFC Administrator

VFC Re-Enrollment Forms - Birth Dose Hospital

Facility Information

Facility Name: IR Physicians [Edit VFC Profile](#)

Provider Pin: 33333Z
Shipping Address: 455 Main Address
City: Omaha
County: Adams
State: NE
Zip: 68501 +4: 8080
Telephone: 981 080 0808 Ext. 8080980808
Fax: 881 808 6860

Warning: Please review all information in this section to confirm that it is correct. If there is any information that is inaccurate, please click on the "Edit VFC Profile" button above to make any necessary corrections.

Organization Type

Birth Dose Hospital

Hospital Address (if different than):
Hospital Address:
City:

Birth Dose Hospital
Adult Immunization Program Provider
Vaccines for Children Provider

3. All fields in **blue** are required:

Organization Type	
Birth Dose Hospital	
Hospital Address (if different than Shipping Address)	
Hospital Address:	<input type="text"/>
City:	<input type="text"/>
County:	<input type="text"/>
Zip:	<input type="text"/> +4: <input type="text"/>
Medical Director or Equivalent	
*Last Name:	Jackson
*First Name:	Sandra
Middle Initial:	<input type="text"/>
*Medical License Number:	45714574
*Medicaid/NPI Number:	125548
Vaccine Manager	
*Last Name:	Smith
*First Name:	Rachel
Middle Initial:	<input type="text"/>
* Telephone:	402 611 2541 Ext. <input type="text"/>
Email:	<input type="text"/>
Backup Vaccine Manager	
*Last Name:	Roberts
*First Name:	Michelle
Middle Initial:	<input type="text"/>
*Telephone:	402 482 2355 Ext. <input type="text"/>
Email:	<input type="text"/>
Provider Population:	
*Total Births per Year:	287

4. Please read the agreement carefully and make sure you fully understand its contents.

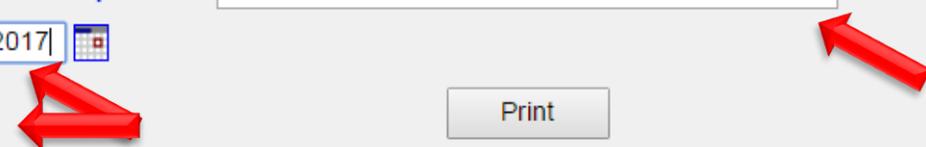
Agreement
<p>To receive publicly funded vaccines at no cost I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the healthcare facility of which I am the medical director or practice administrator or equivalent:</p> <ul style="list-style-type: none">I will maintain all records related to the Nebraska Immunization Program as stated in the Policies and Procedures for a minimum of three years and make these records available to public health officials, including the state or Department of Health and Human Services, (DHHS) upon request.I will immunize newborn babies with state-supplied vaccine at no charge to the patient for the vaccine.I will not charge a vaccine administration fee that exceeds the administration fee cap of \$19.82 per vaccine dose.I will not deny administration of a state purchased vaccine to a patient because they are unable to pay the administration fee.I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records and report clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).

5. To complete the form, please enter the Medical Director's name previously entered on the form and date and then click SAVE:

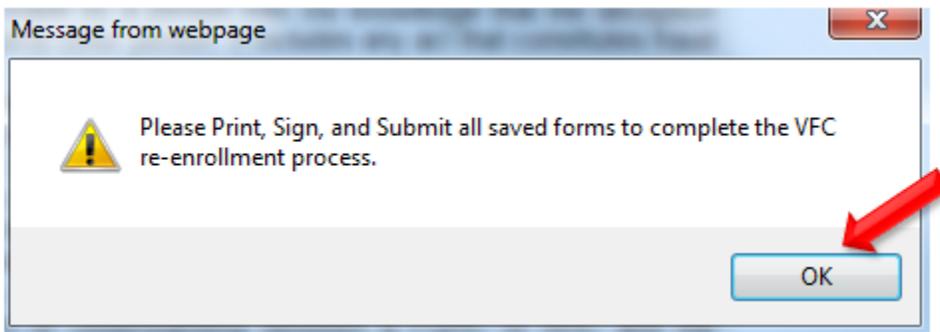
By signing this form, I certify on behalf of myself and all immunization providers in this facility, I have read and agree to the Nebraska Immunization Program enrollment requirements listed above and understand I am accountable for compliance with these requirements.

*Medical Director or Equivalent:

*Date: 



6. Now a pop-up message will appear. Click the OK button:



NOTE: If you click "Save" before completing the form, a pop-up box will display, stating "Warning: You have not completed this re-enrollment form. Saving now will not complete the re-enrollment process. You must complete and print all forms before online re-enrollment is completed."

7. Clicking on it will take you to the top of the page, scroll down the page and verify/update the listed information then click PRINT:

*Medical Director or Equivalent:

*Date: 



Please review, print, sign, and fax this form to the Immunization Program at 402-471-6426 or email it to dhhs.immunization@nebraska.gov.