



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:

- 1) 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.
- 2) I will immunize newborn babies with state-supplied vaccine at no charge to the patient for the vaccine.
- 3) I will not charge a vaccine administration fee that exceeds the administration fee cap of \$19.82 per vaccine dose.
- 4) I will not deny administration of a state purchased vaccine to a patient because they are unable to pay the administration fee.
- 5) 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).
- 6) I will comply with the requirements for vaccine ordering, vaccine accountability, and vaccine management as stated in the Policies and Procedures. I understand to operate in a manner intended to avoid fraud and abuse. The hospital may not store state purchased vaccine in dormitory style refrigerators at any time.
- 7) I will participate in compliance site visits, storage and handling unannounced visits, and other educational opportunities associated with the Nebraska Immunization Program requirements.
- 8) I agree to use NESIIS (Nebraska State Immunization Information System) to order state funded vaccine and manage vaccine inventories.
- 9) I understand this facility or the state/local immunization program may terminate this agreement at any time for personal reasons or failure to comply with these requirements. If I choose to terminate this agreement, I will properly return any unused vaccine.

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 Printed Name: _____

Medical Director or Equivalent Signature: _____

Date: _____