

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

The Annual Provider Recertification process must be completed for individual public and private facilities approved by the State for receipt of publicly vaccines through the Indiana Immunization Division. The Immunization Division maintains this record on file within the Indiana State Immunization Registry's online ordering system, VOMS. The annual documentation must be updated annually or more frequently, if information changes. Each provider facility should designate one individual to complete the Recertification in VOMS. This is usually the Primary VFC Coordinator or the Practice Manager and he/she must have VOMS access.

Upon completion of the Annual Provider Recertification process in VOMS, **providers must print off a copy of the Provider Agreement, obtain the appropriate signature and submit this along with the VFC Profile Report.** These forms should be emailed (preferred method) or faxed to the Indiana Immunization Division using one of the following methods. **Please include the VFC PIN # in the subject line for any email.**

Fax – 317-972-8964 Email – immunize@isdh.in.gov
vaccine@isdh.in.gov

Please contact the VOMS Helpdesk at 1-855-791-0393 if you have any questions.

- ▶ Login into CHIRP at <https://chirp.in.gov>
- ▶ Click the Provider Agreement button in the Navigation Menu

The screenshot shows the VOMS Patient Search interface. On the left is a navigation menu with the following items: Main, Home, Logout, Select Application, Select Organization (IRMS), Select Facility, Select VFC Pin, Message, Favorites, Patient, Vaccinations, Exec. Dashboard, Organization (IRMS), Facilities, Physicians & Vaccinators, Lot Numbers, Orders/Transfers, Alerts, Create/Mew Orders, Search History, Card Storage, and Provider Agreement (circled in red). The main content area is titled 'Patient Search' and includes a link to 'Click here to use the 'advanced' search'. It contains several input fields: First Name or Initial, Last Name or Initial, Birth Date, WIC ID, SIIS Patient ID / Bar Code, Chart Number, Guardian First Name, Mother's Maiden Name, Street, City, State (dropdown), Zip Code, Phone Number, and Country (dropdown set to United States). Below the fields is a note: 'Note: When searching by First and Last Name, you may use the wildcard character % to replace multiple characters and _ to replace a single character.' There is a checkbox for 'Check here if adding a new patient.' and three buttons: 'Add Anonymous', 'Clear', and 'Search'.

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

- Click on the Add button to open the new Recertification
 - This will add the 2018 Recertification Provider Agreement
 - If your site was enrolled during 2017, you will see previously submitted versions of the Provider Agreement. You will still have to hit the Add button to start a new one for 2018.

[Click Here to Print a Recertification Agreement](#)

Provider Agreements									
Select	Select Frozen Vaccine	PDF-Full	Facility Name	PIN	Approval Status	Date	Approval Date	Expiration Date	Create Organization (IRMS)
-->	-->	PDF	**NON MEDICAL FACILITY**	X01X02	PENDING PROVIDER SUBMISSION	06/29/2017			

Showing 1 to 1 of 1 entries

▶ Provider Agreement Add/Edit

Provider Agreement Add/Edit	
Approver Comments:	<div style="border: 1px solid #ccc; height: 40px;"></div>
Status:	PENDING PROVIDER SUBMISSION
VFC PIN:	123456
Organization (IRMS) Name:	ISDH TEST IRMS
Facility Name:	<input type="text" value="ISDH TEST FACILITY"/>
Agreement Signatory:	<input type="text" value="DAVID MCCORMICK"/>
Agreement Signatory Title:	<input type="text" value="MD"/>
Is Information Sharing Agreement current?	<input type="radio"/> Yes <input type="radio"/> No
Last Renewed:	<input type="text" value="2017"/>

- Verify that the VFC PIN, IRMS and Facility Names are correct.
 - If this is incorrect for any reason, call the VOMS Helpdesk at 1-855-791-0393
- Add the name of the Agreement Signatory and the Signatory Title. This should be the Medical Director (MD) or Chief Medical Officer (CMO) at the VFC facility.
 - **This information must match the information submitted as the Signatory under the Contact Details and the Authorized Providers Add/Edit sections.**
 - The medical provider notated here must sign the Provider Agreement that will be printed and returned to the Immunization Division. Signatures must be original, no stamps. A faxed copy is sufficient for the Annual Recertification process.
- Choose the last Provider Recertification that was submitted to the Immunization Division. Providers will choose 2017.

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

► **Address Section**

Facility Address:	
Street Address:	2 N. MERIDIAN
Street Address2:	
City:	INDIANAPOLIS
State:	INDIANA ▼
County:	MARION ▼
Zip Code:	46204
Vaccine Delivery Address:	
Check if vaccine delivery address is the same as facility address: <input type="checkbox"/>	
Street Address:	
Street Address2:	
City:	
State:	--select-- ▼
County:	--select-- ▼
Zip Code:	
Mailing Address:	
Check if mailing address is the same as facility address: <input type="checkbox"/>	
Street Address:	
Street Address2:	
City:	
State:	--select-- ▼
County:	--select-- ▼
Zip Code:	

- Verify the Facility Address section - this should be prepopulated with the data previously submitted to the VFC Program.
 - If this is incorrect or incomplete, it can be corrected in this section.
- Verify the Shipping Address – this should be this should be prepopulated with the data previously submitted to the VFC Program.
 - If this is incorrect or incomplete, it can be corrected in this section.
 - If the address is missing but is the same as the Facility Address, the box can be checked and it will populate this address.
- Verify the Mailing Address – this should be this should be prepopulated with the data previously submitted to the VFC Program.
 - If this is incorrect or incomplete, it can be corrected in this section.
 - If the address is missing but is the same as the Facility Address, the box can be checked and it will populate this address.

Vaccine Delivery Address:	
Check if vaccine delivery address is the same as facility address: <input checked="" type="checkbox"/>	
Street Address:	2 N. MERIDIAN
Street Address2:	
City:	INDIANAPOLIS
State:	INDIANA ▼
County:	MARION ▼
Zip Code:	46204

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

► **Contact Details**

Contact Details:	
Type1:	Primary Vaccine Coordinator ▼
Contact First Name 1, Middle Initial 1, and Last Name 1:	JILL <input type="text"/> KING <input type="text"/>
Phone Number 1:	(317)233-8460
Phone Number Extension1:	<input type="text"/>
Fax Number1:	(317)972-0111
Email Address 1:	JKING@ISDH.IN.GOV
Completed Annual Training 1:	<input type="radio"/> Yes <input type="radio"/> No
Type Of Training Received 1:	--select- ▼

- Up to 4 contacts can be added to this section. It does not matter what order the contacts are added but it must include the following:
 - Signatory Contact Information
 - **This information must match the Signatory information submitted in the Provider Add/Edit - Agreement Signatory and the Authorized Providers Add/Edit sections.**
 - If possible, include an email address for the Signatory.
 - Annual Training is not required for the Signatory.
 - Primary and Back-up Coordinators Contact Information
 - **Please ensure that the email address is verified for both individuals. This is vital as this is used throughout the year to communicate changes and updates to your site.**
 - Both the Primary and Back-up Coordinator must have completed the annual training requirement
 - Indicate what type of training was completed
 - Compliance/Site Visit
 - On-site training with a Health Educator
 - Completion of “You Call the Shots” training online
 - Labor of Love Conference

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

► **Vaccine Offered**

Vaccines Offered

Privately purchased childhood vaccines

All ACIP Recommended Vaccines

Offers Selected Vaccines (This option is only available for facilities designated as Specialty Providers by the VFC Program)

A "Specialty Provider" is defined as a provider that only serves

A defined population due to practice specialty (e.g. OB/GYN; STD Clinic; family planning). Please specify:
 (e.g. We are an STD clinic)

or

A specific age group within the general population of children ages 0-18. Please specify:
 (e.g. We serve children ages 0-6 years)

Local health departments and pediatricians are not considered specialty providers. The VFC Program has the authority to designate VFC providers as specialty providers. At the discretion of the VFC Program, enrolled providers such as pharmacies and mass vaccinators may offer only influenza vaccine.

Select Vaccines Offered by Specialty Provider:

<input type="checkbox"/>	DTaP	<input type="checkbox"/>	Meningococcal Conjugate	<input type="checkbox"/>	TD
<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	MMR	<input type="checkbox"/>	Tdap
<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	Pneumococcal Conjugate	<input type="checkbox"/>	Varicella
<input type="checkbox"/>	HIB	<input type="checkbox"/>	Pneumococcal Polysaccharide	<input type="checkbox"/>	Other: <input type="text"/>
<input type="checkbox"/>	HPV	<input type="checkbox"/>	Polio		
<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Rotavirus		

- If your facility carries privately purchased stock (for non-VFC eligible children) check 'Privately purchased childhood vaccines'. **Please check the box above if you provide privately purchased vaccines.**
- Indicate whether the VFC facility offers all ACIP Recommended vaccines or if the facility only offers 'Selected Vaccines'.
 - If providers offer all ACIP Recommended vaccines, only fill in the appropriate button above.
 - The Specialty Provider section is only for a facility that has been designated as Specialty Provider by the VFC Program.
 - If so, the appropriate facility type and select the vaccines which are administered at the facility.

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

► **Shipping Information**

Shipping Information:					
Monday:	<input checked="" type="checkbox"/>	09:00 ▼	12:00 ▼	13:00 ▼	17:00 ▼
Tuesday:	<input checked="" type="checkbox"/>	09:00 ▼	17:00 ▼	--select- ▼	--select- ▼
Wednesday:	<input checked="" type="checkbox"/>	09:00 ▼	12:00 ▼	13:00 ▼	17:00 ▼
Thursday:	<input type="checkbox"/>	--select- ▼	--select- ▼	--select- ▼	--select- ▼
Friday:	<input checked="" type="checkbox"/>	09:00 ▼	12:00 ▼	--select- ▼	17:00 ▼

- Indicate for each day of the week the times in which the practice is open and shipments may be delivered. **Use only 24-hour or military time notation to denote shipping times.** Please see the attached PDF if you need assistance with the 24 hour time conversion.
 - If the VFC facility has a lunch hour when vaccines cannot be accepted, make sure this is documented in addition to any days the facility is closed.
 - It is essential that the Immunization Division be aware of when the facility is and is not available to accept vaccine shipments.
 - This should be reviewed and updated, as needed, each time a vaccine order is submitted in VOMS to ensure the most up-to-date delivery times are available.
 - Vaccines are never delivered on Saturdays, Sundays and/or national Holidays.

► **Facility Type**

Facility Type:	Public: Public Health Department Clinic ▼
Facility Type Other:	<input type="text"/>
Facility Comments:	<input type="text"/>

- Check only one type of facility. If you are unsure, indicate “Other” and the Deputy Director will evaluate and determine the facility type.
 - There is an option to make a note, if additional information needs to be shared.

► **Complete the Provider Agreement and proceed to the 2nd page**

- Once all information on the Provider Agreement is complete hit Save and Add Provider

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

► Authorized Providers Add/Edit

Authorized Providers [Add/Edit]				
Last Name	First Name	Middle Initial	Title	Specialty
<input type="text" value="McCormick"/>	<input type="text" value="David"/>	<input type="text" value="E"/>	<input type="text" value="MD"/>	<input type="text" value="Pediatrics"/>
<input type="radio"/> Yes <input type="radio"/> No	<input type="text" value="12345678A"/>	<input type="text" value="123456789"/>	<input type="text" value="1234567890"/>	<input type="radio"/> Yes <input type="radio"/> No
Last Name	First Name	Middle Initial	Title	Specialty
<input type="text" value="Jill"/>	<input type="text" value="King"/>	<input type="text" value="M"/>	<input type="text" value="NP"/>	<input type="text" value="Pediatrics"/>
<input type="radio"/> Yes <input type="radio"/> No	<input type="text" value="12345678A"/>	<input type="text" value="123456789"/>	<input type="text" value="1234567890"/>	<input type="radio"/> Yes <input checked="" type="radio"/> No

- Add the name of the medical provider included as the Agreement Signatory in the Provider Agreement section. This section must include the Medical Director (MD) or Chief Medical Officer (CMO) at the VFC site. The Medical Director's name must match that from the Provider Agreement Add/Edit and the Contact Details sections.
 - **This section must match the information submitted as the signatory under the Provider Add/Edit - Agreement Signatory and under the Contact Details.**
 - This section must also include the following:
 - Medical License Number – must be 9 alphanumeric digits – **if you are prompted to use 10 alphanumeric digits, add a zero (0) to the beginning of your medical license number**
 - Medicaid Provider Number – must be 9 numbers
 - NPI Number – must be 10 numbers
- Add additional authorized providers by clicking the Add New Provider button

- Include all authorized provider that are licensed to prescribe vaccines in this section. Each provider submitted must also include the licensing numbers above.
- It is not necessary to include the names of all staff who may administer VFC vaccines, but rather only those who have a medical license or are authorized to write prescriptions (i.e. MD, DO, NP).
- For a large practice, a separate report may be generated and attached when the forms are sent in. For Birthing Hospitals, it is only necessary to include the Medical Director/Chief Medical Officer (CMO).

► Verify CHIRP Users

- Indicate if the CHIRP users listed are still current at your VFC facility.
 - Mark Yes or No.
 - Those individuals that are no longer current at the facility should also be removed in CHIRP. A User Removal Form should be completed and submitted.

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

► Complete the Authorized Providers section and Proceed to the 3rd Page

- Once all information on the Authorized Provider section is complete hit Save and Add Provider/Practice Profile

► Provider/Practice Profile

Provider/Practice Profile

This section is critical in determining the number of doses necessary to vaccinate all eligible children at this facility. Accurately recording your population is the best way to ensure you receive the correct amount of vaccine. Each provider must provide the VFC Profile Report that has actual data from the registry to document the number of children vaccinated at the VFC facility for a 12 month period of time from November 1, 2016 - October 31, 2017. Print and save the report. The report will need to be submitted along with the Provider Agreement. It MUST be included with your recertification paperwork for your packet to be considered complete.

Note:

Click [here](#) to run the VFC profile Report

- Providers must run the VFC Profile Report to document the number of children that have received VFC vaccines at the facility.
 - Click the link above to run the VFC Profile Report
 - **If you click on this link a separate window opens, go ahead and run the report, hit print and then close of that window. This should return you to the Provider Agreement. Do not hit the back button or you may go back to the beginning.**
 - You must enter a vaccine date range. The date range needs to be 12 months to equal a full year. We recommend you run your report from 11/01/16-10/31/17.
 - If you have access to more than one facility in CHIRP, you will also need to choose a facility from the drop down menu.
- Once you see the report in your internet browser, please print and save the report. The report will need to be submitted along with the Provider Agreement. It MUST be included with your recertification paperwork for your packet to be considered complete.
 - If you feel the Profile Report is not accurate or if total number of children vaccinated is not available, please provide further justification with this data.
- Indicate what data source used:

2) What data source (or type of data) was used: (check all that apply)

- Benchmarking
- Medicaid Claims
- Doses Administered
- Provider Encounter Data
- Billing System
- Other

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

► **Complete the VFC Provider Profile and Proceed to Page 4**

Back Save and Certify Frozen Vaccine

- Once all information on the Provider/Practice Profile section is complete hit Save and Add Cold Storage Unit

► **Cold Storage Unit**

- The storage units that store the publicly funded VFC vaccines must be documented in this section.

Cold Storage Unit	
VFC PIN:	000001
Clinic:	ISDH TEST MEMBER
Do you want to be certified for frozen vaccine (Varicella or MMRV)?	<input type="radio"/> Yes <input checked="" type="radio"/> No

- Verify that the VFC PIN and Clinic name are correct
- Indicate if the VFC facility wants to be certified for frozen vaccine
 - Answer Yes or No
 - **This section must be completed in order for a freezer to be added.**

Instructions: Your refrigerator information is required for all units within your practice. Use the "Add" button to add additional units. If you choose to be certified for frozen vaccines, then you must answer the questions below and enter your freezer information.

► **Freezer**

Freezer	
Can freezer maintain an average temperature of -15 °C or 5 °F or colder?:	<input type="radio"/> Yes <input type="radio"/> No
Does freezer have a separate, insulated door?:	<input type="radio"/> Yes <input type="radio"/> No
Freezer 1	Thermometer 1
Freezer Name: <input style="width: 100%;" type="text"/>	Thermometer Serial Number: <input style="width: 100%;" type="text"/>
Freezer Type: --select-- ▼	Thermometer Type: --select-- ▼
Manufacturer: <input style="width: 100%;" type="text"/>	Other Device: <input style="width: 100%;" type="text"/>
Model Number: <input style="width: 100%;" type="text"/>	Temperature Scale: --select-- ▼
Effective From: <input style="width: 100%;" type="text"/>	Date of Last Calibration: <input style="width: 100%;" type="text"/>
Purchase or Issue Date: <input style="width: 100%;" type="text"/>	Calibration Expiration: <input style="width: 100%;" type="text"/>
Inactivate Freezer 1 <input type="checkbox"/>	
<input type="button" value="Add"/>	

- Document if each freezer at the VFC facility maintains the appropriate temperature and if there is a separate, insulated door.

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

- Proceed with documenting each freezer unit at this facility to include (add additional, as needed):
 - Storage Unit Name (required) – facility can provide name for this unit
 - Storage Unit Type (required) – choose one of the following:
 - Combination – freezer only
 - Combination – both freezer and fridge
 - Dorm-Style
 - Standalone – Commercial
 - Standalone – Pharmaceutical
 - Other
 - Manufacturer (required)
 - Model Number (required)
 - Effective Date – beginning date for when unit has been used/approved to store VFC vaccines
 - Purchase or Issue Date – optional, if unknown, leave blank
- Document the thermometer used in the above freezer
 - Thermometer Serial Number
 - Thermometer Type (required) – choose one of the following:
 - Continuous Monitoring Device (glycol) - (ex. Control Solutions, Smart Temps, Sonicu, SensoScientific, PharmaWatch, TempTrak)
 - Digital Data Logger (glycol) - (ex. FridgeTag, DeltaTrak, LogTag)
 - Other, indicate what type of device currently being used
 - Temperature Scale (required)
 - Celsius or Fahrenheit
 - Date of Last Calibration
 - Calibration Expiration (required)

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

► Refrigerator

Refrigerator		Thermometer 1	
Refrigerator Name:	<input type="text"/>	Thermometer Serial Number:	<input type="text"/>
Refrigerator Type:	--select-- ▼	Thermometer Type:	--select-- ▼
Manufacturer:	<input type="text"/>	Other Device:	<input type="text"/>
Model Number:	<input type="text"/>	Temperature Scale:	--select-- ▼
Effective From:	<input type="text"/>	Date of Last Calibration:	<input type="text"/>
Purchase or Issue Date:	<input type="text"/>	Calibration Expiration:	<input type="text"/>
Inactivate Refrigerator 1	<input type="checkbox"/>		

- Proceed with documenting each refrigerator unit at this facility to include (add additional, as needed):
 - Storage Unit Name (required) – facility can provide name for this unit
 - Storage Unit Type (required) – choose one of the following:
 - Combination – fridge only
 - Combination – both freezer and fridge
 - Dorm-Style
 - Standalone – Commercial
 - Standalone – Pharmaceutical
 - Other
 - Manufacturer (required)
 - Model Number (required)
 - Effective Date – beginning date for when unit has been used/approved to store VFC vaccines
 - Purchase or Issue Date – optional, if unknown, leave blank
- Document the thermometer used in the above freezer
 - Thermometer Serial Number
 - Thermometer Type (required) – choose one of the following:
 - Continuous Monitoring Device (glycol) - (ex. Control Solutions, Smart Temps, Sonicu, SensoScientific, PharmaWatch, TempTrak)
 - Digital Data Logger (glycol) - (ex. FridgeTag, DeltaTrak, LogTag)
 - Other, indicate what type of device currently being used
 - Temperature Scale (required)
 - Celsius or Fahrenheit
 - Date of Last Calibration
 - Calibration Expiration (required)

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

► **Final Check**

- Here is a list of important data that you should review to ensure that all necessary information has been submitted to our program and will come over from VOMS accurately.
 - Include VFC Chief Medical Officer (CMO or Signatory) in all 3 locations in the Provider Agreement:

1. Provider Agreement Add/Edit – Agreement Signatory (Section 1)

Provider Agreement Add/Edit	
Approver Comments:	<div style="border: 1px solid gray; height: 40px;"></div>
Status:	PENDING PROVIDER SUBMISSION
VFC PIN:	123456
Organization (IRMS) Name:	ISDH TEST IRMS
Facility Name:	ISDH TEST FACILITY
Agreement Signatory:	DAVID MCCORMICK
Agreement Signatory Title:	MD
Is Information Sharing Agreement current?	<input type="radio"/> Yes <input type="radio"/> No
Last Renewed:	2017

2. Contact Details – Signatory

Type3:	Signatory		
Contact First Name3, Middle Initial 3, and Last Name 3:	DAVID	E	MCCORMICK
Phone Number3:	(317)233-7010		
Phone Number Extension3:			
Fax Number3:			
Email Address3:			
Completed Annual Training3:	<input type="radio"/> Yes <input checked="" type="radio"/> No		
Type Of Training Received3:	--select--		

3. Authorized Providers Add/Edit – Medical Director – you must mark that this Signatory or CMO is the Medical Director at the site in order for this information to carry over to the Provider Agreement page on the PDF.

Authorized Providers [Add/Edit]				
Last Name	First Name	Middle Initial	Title	Specialty
McCormick	David	E	MD	Pediatrics
Active with this Practice	Medical License Number	Medicaid Provider Number	NPI Number	Medical Director or Equivalent
<input checked="" type="radio"/> Yes <input type="radio"/> No	12345678A	123456789	1234567890	<input checked="" type="radio"/> Yes <input type="radio"/> No
Last Name	First Name	Middle Initial	Title	Specialty
Jill	King	M	NP	Pediatrics
Active with this Practice	Medical License Number	Medicaid Provider Number	NPI Number	Medical Director or Equivalent
<input checked="" type="radio"/> Yes <input type="radio"/> No	12345678A	123456789	1234567890	<input type="radio"/> Yes <input checked="" type="radio"/> No

Add New Provider

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

- Verify that the Primary and Back-up VFC Coordinator's information is correct and the email address is spelled correctly. This is vital to allow for ongoing communication with your site.

Contact Details:	
Type1:	Primary Vaccine Coordinator
Contact First Name 1, Middle Initial 1, and Last Name 1:	JILL KING
Phone Number1:	(317)233-8460
Phone Number Extension1:	
Fax Number1:	(317)972-0111
Email Address 1:	JKING@SDH.IN.GOV
Completed Annual Training 1:	<input type="radio"/> Yes <input type="radio"/> No
Type Of Training Received 1:	--select--

- Ensure that you have answered the Cold Storage Unit question, "Do you want to be certified for frozen vaccine?"
 - If you have Varicella or MMRV in your inventory, you must answer this question as 'Yes' so that a freezer unit is added to your Provider Agreement.

Cold Storage Unit	
VFC PIN:	111111
Clinic:	TEST FACILITY
Do you want to be certified for frozen vaccine (Varicella or MMRV)?	<input checked="" type="radio"/> Yes <input type="radio"/> No

Instructions: Your refrigerator information is required for all units within your practice. Use the "Add" button to add additional units. If you choose to be certified for frozen vaccines, then you must answer the questions below and enter your freezer information.

Freezer	
Can freezer maintain an average temperature of 5 °F or colder?:	<input type="radio"/> Yes <input type="radio"/> No
Does freezer have a separate, insulated door?:	<input type="radio"/> Yes <input type="radio"/> No

Freezer 1	Thermometer 1
Freezer Name:	Thermometer Serial Number:
Freezer Type:	Thermometer Type:
Manufacturer:	Other Device:
Model Number:	Temperature Scale:
Effective From:	Date of Last Calibration:
Purchase or Issue Date:	Calibration Expiration:
Inactivate Freezer 1	<input type="checkbox"/>

► **Certify and Submit to State**

By checking and signing this document, I certify that facility/shipping/mailling addresses are accurate to ensure proper delivery. In addition, I certify that the appropriate storage is in place for the storage of all public vaccines.

2018 Annual Recertification Process

Detailed Instructions for Completing Recertification in VOMS

▶ Print PDF of Recertification and obtain necessary signature

- Upon completion of the Annual Provider Recertification process in VOMS, providers must print off a copy of the Provider Agreement, obtain the appropriate signature and submit this along with the VFC Profile Report.
- **Read and sign the Provider Agreement – Please review all the terms of this agreement carefully.** In order to participate in the Indiana Immunization Division Vaccines for Children (VFC) Program and receive publicly funded vaccines, the Medical Director (CMO) or equivalent must sign and abide by the conditions listed in the agreement, on behalf of themselves and all the practitioners, nurses and others associated with this medical office, group practice, Health Maintenance Organization, community/migrant/rural clinic health department or other entity of which the provider is the physician on record or equivalent.

Upon completion of the Annual Provider Recertification process in VOMS, providers must print off a copy of the Provider Agreement, obtain the appropriate signature and submit this along with the VFC Profile Report. These forms should be emailed (preferred method) or faxed to the Indiana Immunization Division using one of the following methods. Please include the VFC PIN # in the subject line for any email.

Fax – 317-972-8964

Email – immunize@isdh.in.gov or vaccine@isdh.in.gov

Please contact the VOMS Helpdesk at 1-855-791-0393 if you have any questions.