



SOUTH CAROLINA VACCINE PROGRAM(S) DIS-ENROLLMENT FORM (VFC OR SC STATE)

VFC PIN (6-Digit)	County	Effective Date
Provider Name of Physician's Office, Practice, Clinic, etc.		Today's Date
Address (Number and Street)		
City	State	Zip Code
Contact Person		
Telephone ()	FAX ()	

The Immunization Division's VFC Program must be notified one (1) month prior to dis-enrollment from Vaccine Programs in South Carolina.

*Reason for Dis-enrollment (Choose all that apply)	
<input type="checkbox"/> Closing Office <input type="checkbox"/> No longer seeing VFC-eligible children <input type="checkbox"/> Dis-enrolling in SC State Vaccine Program Only <input type="checkbox"/> Not Using VFC Vaccine <input type="checkbox"/> No Longer Enrolled in Medicaid <input type="checkbox"/> Too Much Paperwork <input type="checkbox"/> Staffing Issues	<input type="checkbox"/> Physician No Longer Practicing <input type="checkbox"/> Relocating Out of Area *New County: _____ *New Address: _____ <input type="checkbox"/> Other: *(Specify) _____ _____

*Required Fields

Signature of Medical Director/Equivalent (ESA): _____ Date: _____

Send this form to: South Carolina Division of Immunizations; Attn: Vaccines For Children (VFC) Program.
 Fax Form to: (803) 898-0326
 Email Completed Form to: immunize@dhec.sc.gov

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INSTRUCTIONS FOR COMPLETING

Purpose: The purpose of this form is to capture all information necessary from the Vaccines For Children (VFC) program provider's office regarding their dis-enrollment from the VFC or SC State Vaccine programs. The Medical Director or Equivalent (Electronic Signature Authority [ESA]) who signed the Federal VFC Program Provider Agreement (DHEC 1144) must sign this disenrollment form.

Item-by-Item Instructions:

1. Complete Demographic information: VFC PIN, Name of Provider, Address, Contact Person, County, Date, and Reason for Dis-enrollment, Date dis-enrollment is to be effective.
2. Complete Reason for Dis-Enrollment (choose all that apply).
3. Signature of ESA and Date ESA signed form.
4. Mail, email, or fax this form to the Immunization Division office **one (1) month before** the date of your dis-enrollment.

Office Mechanics and Filing:

1. Provider must fax the completed form to DHEC Immunization Division (803-898-0318).
2. Form Retention:
-DHEC Immunization Program: retain providers' copies for (3) three years as required by the Federal Immunization Program.