



VFC PROVIDER INFORMATION

Please complete the following information.

The DHEC Immunization Division will keep this record on file with your Provider Agreement. This form must be **updated annually** or more frequently if the address or contact information changes. Mail or FAX the form to DHEC, Immunization Division, 1751 Calhoun Street, Columbia, S.C. 29201 (FAX # 803-898-0318) upon completion.

A. IRS Business Tax I.D. Number: _____ Today's Date: _____

B. Facility Name: _____
 or
 Provider Name: _____
Last Name First Name MI

C. 1. Shipping Contact

_____ Last Name First Name MI

Vaccine Delivery Address (no PO Boxes): _____

_____ City State Zip Code County

(____) _____ (____) _____

_____ Telephone Fax E-Mail Address

2. Mailing Contact (if different from above)

_____ Last Name First Name MI

Mailing Address (if different from shipping): _____

_____ City State Zip Code County

(____) _____ (____) _____

_____ Telephone Fax E-Mail Address

D. Days of the week and hours not available to receive vaccine: _____

E. Type of Facility (please check only one box):

- | | |
|---|---|
| <input type="checkbox"/> Private Practice (Individual or Group) | <input type="checkbox"/> Other Public Facility |
| <input type="checkbox"/> Private Hospital | <input type="checkbox"/> Other Private Facility |
| <input type="checkbox"/> Federally Qualified Health Center or Rural Health Clinic | |

Please list below all physicians and practitioners who will be administering VFC vaccine in this practice: (add additional pages if necessary)

Name	Medical License # or Advanced Practice License #	National Provider Identifier (NPI)

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Instructions For Completing DHEC 1134A

Purpose:

The purpose of the PROVIDER INFORMATION is to document general demographic information about a VFC provider along with a listing of all physicians and practitioners.

Item-By-Item Instructions:

1. In Sections A, B and C, provider will complete demographic information.
2. In Section D, provider will indicate shipping restrictions.
3. In Section E, provider will indicate the type of facility, and for each physician or practitioner, enter the name, Medical License number or Advanced Practice number and National Provider Identifier (NPI).

Office Mechanics and Filing:

1. The completed PROVIDER INFORMATION is kept on file by DHEC Immunization Division indefinitely as long as the provider continues enrollment in the VFC program. The form is retained for seven consecutive years after disenrollment or inactivation of the provider from the VFC program.