Rhode Island State-Supplied Vaccine Program
Enrollment Form

Date ____________________

Facility/Practice Information

Name ____

Address ____

Phone number ____

Email ____

Name of lead physician or lead licensed prescriber and credentials (e.g. MD, DO, RPH, etc.)

____

Professional license number ____

Facility/Practice type, (e.g. adult, internist, pediatrician, mass immunizer, pharmacy, OBGYN, nursing home, community health center, etc.)

____

Will you be sharing office space with another medical practice? Yes No

If yes, please list practice name here: ____

Check one:

If yes, we will be sharing their vaccine-only refrigerator

If yes, we will have our own vaccine-only refrigerator

Please email this completed form to heidi.wallace@health.ri.gov. You will be contacted with next steps for enrollment.

While your enrollment form is being processed, we recommend that you familiarize yourself with the following Terms & Conditions:

1. ***SSV Program***
   https://kidsnet.health.ri.gov/llr-practice-osm-prod/pdf/Terms-&-Conditions-SSV.pdf

2. ***Federal Vaccines for Children (VFC) Program***
   https://kidsnet.health.ri.gov/llr-practice-osm-prod/pdf/Terms-&-Conditions-VFC.pdf