



State-Supplied Vaccine Program Enrollment Form

Thank you for your interest in enrolling in the State-Supplied Vaccine Program. Please complete this form and email it to Nicole.Selema@health.ri.gov. See links to *Terms & Conditions* at the end of this form. The Office of Immunization will contact you after reviewing your submitted enrollment form. **NOTE: Enrollment for vaccine ordering allows access to KIDSNET/RICAIR and data reporting. All fields are required unless indicated.**

Date: _____

Facility/Practice Information

Name: _____

Address: _____ City: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Facility/Practice Type (e.g. Adult, Internist, Pediatric, Community Immunizer, Pharmacy, Nursing Home, Health Center, OBGYN, etc.): _____

Lead Physician/Lead Prescriber Information

First Name: _____ Last Name: _____

Credentials (e.g., MD, DO, RPH, NPP, APRN, MW, PA, CNM): _____

Professional License Number: _____

Vaccines Interested in Administering (Select all that apply): COMPLETE THIS SECTION ONLY IF ORDERING VACCINES

- Routine/Monthly Flu COVID-19 RSV pediatric (<19 years old) adult (>19 years old)

COMPLETE THIS SECTION ONLY IF YOU DO NOT WANT TO ORDER VACCINES AND NEED KIDNET-RICAIR ACCESS AND REPORTING ONLY

- KIDSNET/RICAIR Web Access (view data and reports access)
 Immunization HL7 Data Reporting only (Electronic data reporting).

Electronic Health System (EHR) Information

EHR System Type: _____

EHR Administrator/IT Contact Information

First Name: _____ Last Name: _____

Email: _____

Terms and Conditions

[Rhode Island State-Supplied Vaccine \(SSV\) Program Terms & Conditions](#)

[Vaccines for Children \(VFC\) Program Terms & Conditions](#)