



IMMUNIZATION PROVIDER ENROLLMENT REQUEST

State Form 54048 (8-09)

Indiana State Department of Health, Immunization Program

INSTRUCTIONS: 1. Please complete the information below if you are interested in learning how to offer the Vaccines for Children program, CHIRP, or CHIRP Interface with Electronic Medical Records in your practice.
2. Fax completed form to (317) 233-3719.

A. Provider Information

Facility Name _____ Date of Request (month, day, year) _____

Contact Name _____ Title _____

Physician Name _____

Mailing Address (number and street) _____

City _____ ZIP Code _____ County _____

Telephone _____ Fax _____

Email Address _____

B. I would like an Immunization Program representative to contact me about

Vaccines for Children (VFC) Yes No

Children & Hoosiers Immunization Registry Program (CHIRP) Yes No

CHIRP Interface with Electronic Medical Records Yes No

Other _____ Yes No

C. Refrigerator Information (Only Complete if Requesting to be contacted regarding VFC)

Do you have a full size refrigerator? Yes No

Does your refrigerator have a thermometer? Yes No

Do you currently keep a Refrigerator Temperature Log? Yes No

Does your freezer have a thermometer? Yes No

Do you currently keep a Freezer Temperature Log? Yes No

D. Additional Information

E. How did you hear about the program?

Conference Exhibit

Current Provider Referral

During a Presentation

Online

Meeting with an Immunization Program Representative

Other _____