DATE:

VACCINE CLINIC REQUEST FORM

Revision Date: 10.31.22

CLINIC REQUESTS MUST BE MADE A MINIMUM OF 7 BUSINESS DAYS IN ADVANCE

REQUESTER *(Please complete this section only and then save and email form to iapsupport@srhd.org)*

REQUESTING FACILITY OR ORGANIZATION | HOSTING LOCATION NAME & ADDRESS | CITY | ZIP

CONTACT FIRST NAME | LAST NAME | PHONE | EMAIL

PROPOSED CLINIC DATE CHOICE #1 | START TIME | ○ a.m. ○ p.m. | END TIME | ○ a.m. ○ p.m.

PROPOSED CLINIC DATE CHOICE #2 | START TIME | ○ a.m. ○ p.m. | END TIME | ○ a.m. ○ p.m.

CLINIC TYPE ☐ CHILDREN ☐ ADULTS ☐ COVID-19 | NUMBER OF EXPECTED CHILDREN | NUMBER OF EXPECTED ADULTS

HEALTH EQUITY CONSIDERATION | ETHNICITY | HEALTH INSURANCE STATUS

CHILDREN VACCINE REQUESTED

☐ DTAP	☐ DTAP / HEB B / IPV	☐ DTAP / HEP B / HIB / IPV	☐ DTAP / HIB / IPV	☐ DTAP / IPV	☐ HEP A
☐ HEP B	☐ HIB	☐ HPV9	☐ INFLUENZA	☐ FLU-MIST	☐ IPV
☐ MENACWY	☐ MEN B	☐ MMR *(LIVE)*	☐ MMR / V *(COMBO & LIVE)*	☐ PCV-13 / PCV-15	☐ TDAP
☐ VARICELLA	☐ COVID-19 *(PFIZER)* 6 MOS-4 YRS OLD		☐ COVID-19 *(PFIZER)* 5-11 YRS OLD		
☐ COVID-19 *(PFIZER)* 12 YRS & OLDER, #1, #2	☐ COVID-19 *(PFIZER BIVALENT BOOSTER)* 5-11 YRS OLD				
☐ COVID-19 *(PFIZER BIVALENT BOOSTER)* 12 YRS & OLDER	☐ OTHER *(SPECIFY)*				

ADULT VACCINE REQUESTED

☐ HEP A / B	☐ HPV9	☐ IPV	☐ INFLUENZA	☐ MMR	☐ PCV-20
☐ SHINGLES	☐ TDAP	☐ COVID-19 *(NOVAVAX)*	☐ COVID-19 *(PFIZER)*	☐ COVID-19 BIVALENT BOOSTER *(PFIZER)*	
☐ OTHER *(SPECIFY)*					

EVENT TYPE | INTERPRETIVE SERVICES NEEDED? ○ YES ○ NO | IF YES, WHAT LANGUAGE(S)

WHAT CAN THE REQUESTER CONTRIBUTE TO SUPPORT THIS CLINIC? *(recruitment, staff on-site to support the event, computers, tables, other logistics, vaccinators, CHWs, etc.)*

WILL YOU NEED VACCINATORS / SUPPORT STAFF FOR CLINIC ○ YES ○ NO | PROMOTIONAL MATERIALS NEEDED ○ YES ○ NO ☐ FLYER ☐ SOCIAL MEDIA ☐ SRHD WEBSITE

IF VACCINE LIAISON OR PACK-N-GO, CONTACT NAME OF PICK-UP PERSON | PHONE #

PICK-UP TIME ○ a.m. ○ p.m. | DROP-OFF TIME ○ a.m. ○ p.m.

WHAT IS THE NAME OF THE PRECEPTOR OR THE LEAD VACCINATOR? | PHONE #

To submit this form, please save it, and email it to iapsupport@srhd.org

IAP TEAM *(After making any changes in this section, select the save file icon in the top left corner before forwarding to AA)*

ASSIGNED TEAM MEMBER | DESCRIPTION OF POPULATION TO BE SERVED

HAS AN ASSESSMENT BEEN COMPLETED TO CONFIRM THAT THE TARGET POPULATION IS INTERESTED IN THIS SERVICE? ○ YES ○ NO

IF COVID-19 CLINIC, HOW MANY DOSES REQUESTED? PFIZER BOOSTER | NOVAVAX | PFIZER

NEED FOR CHWs? ○ YES ○ NO | IF YES, DESCRIBE NEED

LOCATION CLASSIFICATION | METHOD | VACCINATOR TYPE | # OF VACCINATORS NEEDED | # OF STATIONS

OF SUPPORT PERSONNEL NEEDED | IF USING MRC, WAS REQUEST SENT TO MRC COORDINATOR? ○ YES ○ NO ○ N/A | HAS COMMUNICATIONS BEEN NOTIFIED? ○ YES ○ NO ○ N/A

PREPMOD CLINIC? ○ YES ○ NO | APPOINTMENTS REQUIRED? ○ YES ○ NO

NOTES | PENDING FOR MORE DETAILS ○ YES ○ NO

☐ **IF PENDING,** NOTIFIED AA SO DOCUMENTS COULD BE STARTED AND/OR FINALIZED

☐ **COMPLETE** NOTIFIED AA TO UPDATE DETAILS ON DATA SHEET & CALENDAR

☐ AA HAS COMPLETED ALL TASKS - **CLINIC LEAD HAS UPDATED STAFF INFO IN PREPMOD *(IF NEEDED)* AND HAS NOTIFIED ALL APPROPRIATE STAFF CLINIC DETAILS**

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AA CONFIRMATION

CLINIC CREATED IN PREPMOD ◯ **YES** ◯ **NO** ◯ **N/A** **PREPMOD CLINIC ID** **DATA SHEET CREATED** ◯ **YES** ◯ **NO**

CLINIC ADDED TO IMMS CALENDAR WITH PREPMOD CLINIC ACCESS LINK & PREPMOD REGISTRATION LINK ◯ **YES** ◯ **NO** ◯ **N/A**

PENDING FOR MORE INFO ◯ **YES** ◯ **NO** **CLINIC DATA SPREADSHEET UPDATED** ◯ **YES** ◯ **NO**

☐ **COMPLETE** - RECEIVED UPDATES FROM IAP TEAM MEMBER, UPDATED ALL NECESSARY ITEMS, ATTACHED COMPLETED CLINIC REQUEST FORM & DATA SHEET TO IMMS CALENDAR & SENT INVITE TO CLINIC LEAD AND BACKUPS