DATE:

VACCINE CLINIC REQUEST FORM

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

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	TDAP
VARICELLA	COVID-19 *(PFIZER)*	OTHER *(SPECIFY)*			

ADULT VACCINE REQUESTED

HEP A	HEP B	HEP A / B	HPV9	INFLUENZA	MMR
PCV-13	PPSV-23	SHINGLES	TDAP	COVID-19 *(J & J)*	COVID-19 *(MODERNA)*
COVID-19 *(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? J & J | MODERNA | PFIZER

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

LOCATION CLASSIFICATION | METHOD | HEALTH EQUITY CONSIDERATION | VACCINATOR TYPE | # OF VACCINATORS NEEDED | # OF STATIONS

OF SUPPORT PERSONNEL NEEDED | IF USING MRC, WAS REQUEST SENT TO MRC COORDINATOR? YES NO

HAS COMMUNICATIONS BEEN NOTIFIED? YES NO | 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**

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

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