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Texas Department of State
Health Services

The Texas Immunization Registry:

Texas DSHS Immunization Portal Registration Guide



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Introduction

Organizations interested in receiving the COVID-19 vaccine are required to register through the Texas DSHS Immunization Portal. The registration process contains three sections:

1. Texas Immunization Registry (ImmTrac2) Registration
2. Pandemic Provider Enrollment
3. Texas Vaccines for Children

Our recommended browser is Google Chrome. See *Figure 1: Chrome Icon*.



Figure 1: Chrome Icon

To begin, go to the website EnrollTexasIZ.dshs.texas.gov and select the “Click to Register” button. See *Figure 2: Click to Register*.



Figure 2: Click to Register

Part A: Texas Immunization Registry (ImmTrac2) Registration

Step A1: Registration Type.

Select the type of organization you represent and click **Continue**. See *Figure 3: Organization Types*.



Figure 3: Organization Types

Step A2: What to Expect.

Review this section and click **Continue**.

ImmTrac2 Participating Organizations

If your organization participates with the Texas Immunization Registry (ImmTrac2), you will need the ImmTrac2 Organization Code.

TVFC Provider Organizations

If your organization previously enrolled with the Texas Vaccines for Children and Adult Safety Net Program, you will need your TVFC/ASN PIN.

Information Needed to Complete This Registration

All organizations will need to provide the following information to complete the registration process:

1. Organization Name
2. Organization's Physical and Mailing Addresses
3. Organization's Phone Number (main phone number)
4. Organization's Fax Number
5. Your Contact information: First Name, Last Name, Phone Number and a unique email address
6. Organization Point of Contact: First Name, Last Name, Phone Number and a unique email address
7. Primary Registry Point of Contact: First Name, Last Name, Phone Number and a unique email address
8. Responsible Medical Professional: First Name, Last Name, Phone Number, a unique email address, Texas Medical License, License Type, Individual National Provider Identification Number (NPI), Specialty, and Medicaid ID

Step A3: Organization Identification.

Existing Organization Search

Organizations who have previously registered with one of the following DSHS programs should select **YES**. All other organizations should select **NO**. See *Figure 4: Existing Organization Search*, *Figure 5: ImmTrac2 Org Code Search* and *Figure 6: TVFC/ASN PIN Search*.

Note that:

- The Texas Immunization Registry (ImmTrac2) Org Code contains four letters followed by four numbers.
- The Texas Vaccines for Children (TVFC) or Adult Safety Net (ASN) PIN numbers contain six numbers.

Existing Organization Search

*Does this organization currently participate with the Texas Immunization Registry, ImmTrac2? Yes No

*Does this organization currently participate in Texas Vaccines for Children and Adult Safety Net Program (TVFC)? Yes No

Figure 4: Existing Organization Search

Enter your ImmTrac2 Organization Code below and click search

*Enter the ImmTrac2 Code for this organization:

Figure 5: ImmTrac2 Org Code Search

Enter your Texas TVFC/ASN PIN below and click search

*Enter the TVFC/ASN PIN for this organization:

Figure 6: TVFC/ASN PIN Search

If you are not sure if your organization is registered in ImmTrac2 (and have an Org Code) or in TVFC/ASN (and have a PIN), then you can check in the [Lookup Tool](#).



Facility's Physical Address and Clinic Information.

Single Facility Organization Registration

Facility's Physical Address

Organization Name*		Doing Business As (Alternate Clinic Name)	
<input style="width: 90%;" type="text"/>		<input style="width: 90%;" type="text"/>	

*Is this organization part of a larger multi-site parent organization (ie. HealthSystem, Medical Group or Pharmacy Chain)? Yes No

Address 1*		Suite #	
<input style="width: 90%;" type="text"/>		<input style="width: 90%;" type="text"/>	

Zip Code*	City*	County*	State*
<input style="width: 80%;" type="text"/>	<input type="text" value="Click to Select City"/>	<input type="text" value="Click to Select Coun"/>	<input type="text" value="Texas"/>

Phone Number*	Fax	Organization Email Address*
<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>	<input style="width: 90%;" type="text"/>

*Is the Mailing Address for this organization the same as the facility's Physical Address displayed above? Yes No

Clinical Information

*Please select the type of organization you are enrolling.

*Is this organization authorized to administer immunizations? Yes No

- Adolescent Only Provider (Private)
- Adolescent Only Provider (Public)
- Birthing Hospital
- Child care
- College/University
- Community Health Center
- Correctional Facility
- Dialysis Center
- Distributor
- Drug Treatment
- Emergency Management Shelter
- Family Planning
- Federally Qualified Health Clinic
- Fire Department/EMS

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Figure 7: Single Facility Organization Registration



See *Figure 7: Single Facility Organization Registration* (above) and enter the following fields:

- Organization Name
- Doing Business As
- Is this organization part of a larger multi-site parent organization? (*Required*)
See *Figure 8: Parent/Child Organization* and *Figure 9: Stand-Alone Site*.

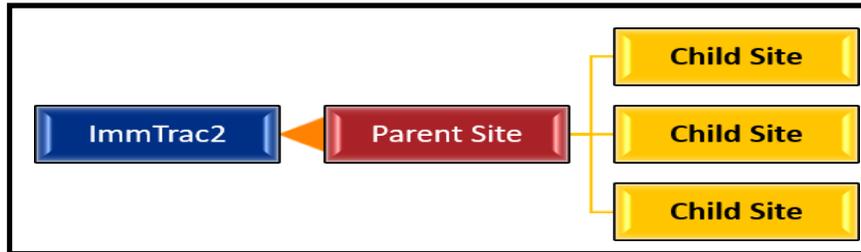


Figure 8: Parent/Child Organization

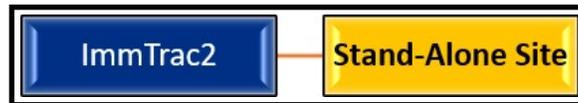


Figure 9: Stand-Alone Site

Select **YES** if:

- Your parent organization is currently registered in ImmTrac2
- You know the TX IIS ID for the parent organization

Select **NO** if:

- You are part of a larger multi-site organization, but the parent site is NOT registered in ImmTrac2, or
- You do not know the TX IIS ID for the parent organization

- Address
- Zip code
- City
- County
- State
- Phone number
- Organization email address
- Select "Yes" or "No" to "Is the Mailing Address for this organization the same as the facility's Physical Address displayed above?"
- Select from a drop-down box the type of organization you are enrolling. If you do not see an exact match, please choose the closest description applicable. For example, if you are a free-standing emergency room, select Hospital. You will be able to provide further clarity in subsequent steps of the provider enrollment process.
- Select "Yes" or "No" to "Is this organization authorized to administer immunizations? If "Yes", then select the type of immunizations.

Click **Continue** when finished and ready to go on.

Review Prior Registrations.

Review any previous registrations that match the information you entered. If your provider site is listed below, check the corresponding box, and click **Continue**. See *Figure 10: Previous Registration is a Match*.

The following provider sites were found. Please select your provider site from the list below. If your provider site is not listed below, select **New Provider site** and click "Continue" button.

A. Provider Site is in the list below:

Select	#	County	Provider Site Name	Address	City	Zip	Organization NPI	TVFC/ASN PIN
<input checked="" type="checkbox"/>	1	Travis	Matt's Test Org	12345 Street	Austin	78727		999999
<input type="checkbox"/>	2	Travis	Matt's Test Org 2	12345 Physical Address Line 1	Austin	78727		

Figure 10: Previous Registration is a Match

If your provider site is not listed, check the radio button "B", and click **Continue**. See *Figure 11: Provider Site Not on List of Registrations*.

The following provider sites were found. Please select your provider site from the list below. If your provider site is not listed below, select **New Provider site** and click "Continue" button.

A. Provider Site is in the list below:

Select	#	County	Provider Site Name	Address	City	Zip	Organization NPI	TVFC/ASN PIN
<input type="checkbox"/>	1	TRAVIS	Matt's Test Org	12345 Street	Austin	78727		999999
<input type="checkbox"/>	2	Travis	Matt's Test Org 2	12345 Physical Address Line 1	Austin	78727		

B. Provider site is not in the list above and is a **New Provider Site**.

Figure 11: Provider Site Not on List of Registrations

Step A4: Your Information.

Submit data about yourself and create a password to access the site in the future.

The information provided here will be used to create a username and password for the account.

If the page times out during the enrollment process, please sign back in using the following format for the username: **firstname.lastname**. If you do not have a password, enter the username and click **Forgot Password**. The password reset information will be sent to the registered email address. Once completed, click **"Save and Continue"**. See *Figure 12: Submit Data About Yourself*.



First Name*	MI	Last Name*
Clark		Kent
Phone <input type="checkbox"/> Same As Clinic Phone Number		Email Address
512 324 7785 x		ClarkKent@gmail.com
*Title		
Reporter		
Please create a password to access this site in the future. Your password MUST be 8 characters in length, include at least 1 letter, 1 number and 1 special character (for example #S%l@&).		
Password*	Confirm Password*
Secret Question*	What is your favorite cartoon character?	Secret Answer* Superman

Figure 12: Submit Data About Yourself

Record your username and password in a secure location for future reference. See Figure 13: Your Information Has Been Saved.

YOUR INFORMATION HAS BEEN SAVED!

If you choose to exit now, you may return to the Texas DSHS Immunization Portal at anytime to complete your organization's ImmTrac2 registration.

PLEASE NOTE: If you exit now, you will need to login to continue.

Your Texas DSHS Immunization Portal username is: Clark.Kent

Figure 13: Your Information Has Been Saved

Step A5: Contacts.

Enter Points of Contact and Responsible Medical Professional Info. **Note:** Carefully read each description to determine which contacts at your organization best match the roles below and provide contact information for each.

Organization Point of Contact (POC)

The Organization Point of Contact (POC) serves as the Organization's main POC for ImmTrac2. This individual is responsible for completing the ImmTrac2 registration/renewal and updating the organization's demographics and/or a user's profile. The Organization POC may be the assigned Registry and/or Texas Vaccines for Children and Adult Safety Net Program (TVFC) contact and may assign individuals within their organization as Registry and/or TVFC contacts. This individual may also be the Authorized Signer with the ability to electronically sign the registration/renewal.

Are you the Organization Point of Contact (POC)?

- If so, select **YES**.
- If not, select **NO**. Please include their name, title, and contact information.

Primary Registry Contact

The Primary Registry contact is the main point of contact for ImmTrac2 related matters and client immunization related items. The ImmTrac2 Primary Registry contact may be the assigned Organization Point of Contact (POC) and/or Texas



Vaccines for Children and Adult Safety Net Program (TVFC) contact. These roles may or may not be the same person.

Are you the Primary Registry Contact?

- If so, select **YES**.
- If not, select **NO**. Please include their name, title, and contact information.

Responsible Medical Professional

Organizations MUST have a designated Chief Medical Officer or Senior Practicing Provider for the "Responsible Medical Provider" section. They must be a Texas licensed medical provider and/or a licensed prescribing authority for Organizations administering immunizations. See *Figure 14: Responsible Medical Provider Information*.

Last Name*	<input type="text"/>	First Name*	<input type="text"/>
Telephone*	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Email*	<input type="text"/>
*License Type	<input type="text"/>	Specialty	<input type="text"/>
*Texas License #	<input type="text"/>		
Medicaid ID	<input type="text"/>	*Provider's NPI	<input type="text"/>

Figure 14: Responsible Medical Provider Information

The format for license numbers are:

- APN = Up to seven numbers. If there are less than seven, add zeroes to the front of the number. It does not require "AP" at the beginning. For example: 1234567.
- MD = one letter followed by four numbers. For example: N5678.
- PA = "PA" followed by four or five numbers. For example: PA12345.
- NPI = Ten numbers. For example: 1234567891.

Step A6: Manner of Usage.

How does your organization plan to report immunization data to ImmTrac2? Through direct data entry or electronic data exchange?

Organizations who plan to manually enter the data online in ImmTrac2 should select "**Direct Data Entry**". See *Figure 15: Direct Data Entry Selection*.

*How does your organization plan to report its immunization data to the SIIS?	
<input checked="" type="radio"/>	Direct Data Entry- Manually enter data into the SIIS web application.
<input type="radio"/>	Electronic Data Exchange (HL7)- Electronically report data to SIIS through an interface from EHR.

Figure 15: Direct Data Entry Selection

Organizations who plan to electronically report data should select “**Electronic Data Exchange (HL7)**”. See *Figure 16: Electronic Data Exchange (HL7) Selection*.

***How does your organization plan to report its immunization data to the SIIS?**

Direct Data Entry- Manually enter data into the SIIS web application.

Electronic Data Exchange (HL7)- Electronically report data to SIIS through an interface from EHR.

Figure 16: Electronic Data Exchange (HL7) Selection

For electronic submitters, please indicate the following (see *Figure 17: HL7 Messaging Contact*):

- Are you the HL7 messaging contact for your site?
 - If so, select **YES**.
 - If not, select **NO**. Please include their name, title, and contact information. Additional HL7 contacts can be added by selecting, “Click to add another HL7 Messaging Contact”.

***Are you the HL7 messaging contact for your site?** Yes No

Provide the HL7 Messaging Contact's information below: [+ Click to add another HL7 Messaging Contact](#)

First Name*	Last Name*	Phone Number*	Email Address*
<input type="text" value="Paul"/>	<input type="text" value="Piper"/>	<input type="text" value="713 557 3242"/>	<input type="text" value="Paul.Piper@yahoo.com"/>
<input type="text" value="David"/>	<input type="text" value="Disney"/>	<input type="text" value="832 677 2552"/>	<input type="text" value="David.Disney@gmail.co"/>

Figure 17: HL7 Messaging Contact

- Electronic Health Record (EHR) Information. See *Figure 18: Electronic Health Record (EHR) Information*.
 - Select the company name of your EHR Vendor.
 - Select the EHR Product used in this location.
 - Can the EHR send HL7 2.5.1 formatted data?
 - Select/Add your Electronic Health Record Contact.
 - If this is your first time registering, you will need to select [+].

Electronic Health Record (EHR)

Select the company name of your EHR Vendor.

Select the EHR Product used in this location.

Can the EHR send HL7 2.5.1 formatted data? Yes No

Select/Add your Electronic Health Record Contact from the company selected above. Add New [+]

Figure 18: Electronic Health Record (EHR) Information

- Once selected, the EHR contact fields will display (see *Figure 19: EHR Contact Name*).

EHR Contact Name (Not in the list above)			
First Name	Last Name	Phone Number*	Email Address*
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
<small>While entering other contact name for EHR, please enter atleast phone number or email address.</small>			

Figure 19: EHR Contact Name

Step A7: Review.

Review the registration information entered and choose to print this page or click Continue.

Step A8: Agreement.

Site Agreement.

This step deals with the ImmTrac2 Enrollment Agreement. If you are authorized to sign on behalf of the clinic, select the box on the left. See *Figure 20: I Can Sign for This Clinic*. Skip to [Sign & Submit Site Agreement](#) for further instructions.

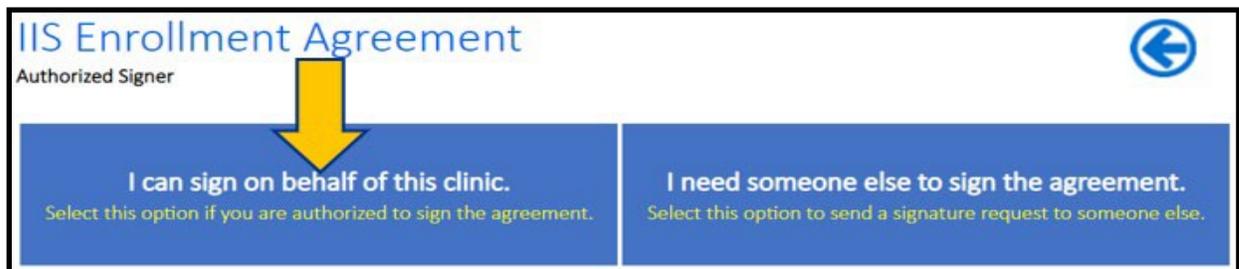


Figure 20: I Can Sign for This Clinic

If you are **NOT** authorized to sign on behalf of the clinic, select the box on the right. See *Figure 21: I Need Someone Else to Sign*.

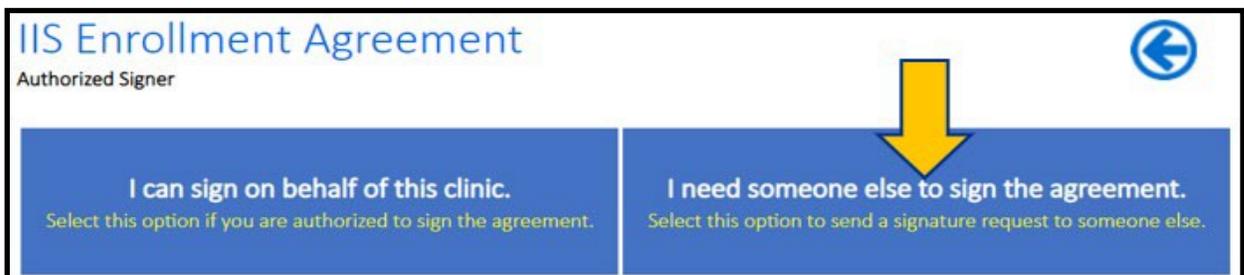


Figure 21: I Need Someone Else to Sign

Choose which contact is responsible to sign and submit the site agreement. Then select, **Send for Signature**. The authorized signer will receive an email to the

address listed on this page. See *Figure 22: Choose the Contact to Sign and Submit Agreement*.

***Choose one selection from the options below:**

I want to send the Agreement to the Responsible Medical Professional for signature.

***Confirm the Responsible Medical Professional's information is correct and click "Send for Signature".**

First Name*	MI	Last Name*	Email Address of Authorized Signatory*
First Name		Last Name	Email@dshs.texas.gov

Click the send for signature button below. An invitation will be sent to the person above at the email address indicated with instructions to sign the Enrollment form online.

I want to send it to someone else.

Need to add a new contact? Select "Add New".

*Use the pick-list to the right to select someone from this clinic. Otherwise, click Add New.

***Confirm the information is correct below and click "Send for Signature".**

First Name*	MI	Last Name*	Email Address of Authorized Signatory*

Click the send for signature button below. An invitation will be sent to the person above at the email address indicated with instructions to sign the Enrollment form online.

Figure 22: Choose the Contact to Sign and Submit Agreement



The authorized signer will receive the email below. To access the ImmTrac2 agreement, they will need to click the hyperlink and copy the unique signature code included in the email. See *Figure 23: Email Requesting Action by Authorized Signer*.

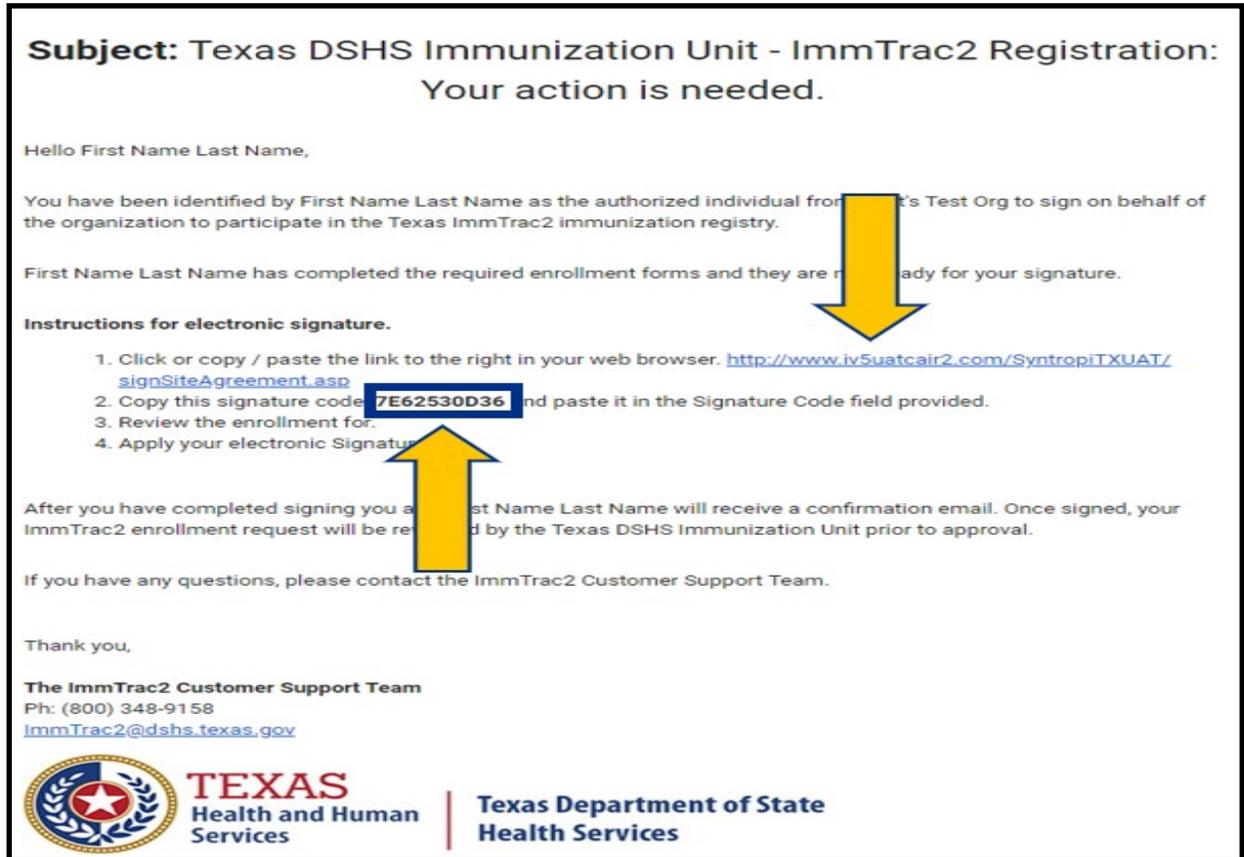


Figure 23: Email Requesting Action by Authorized Signer

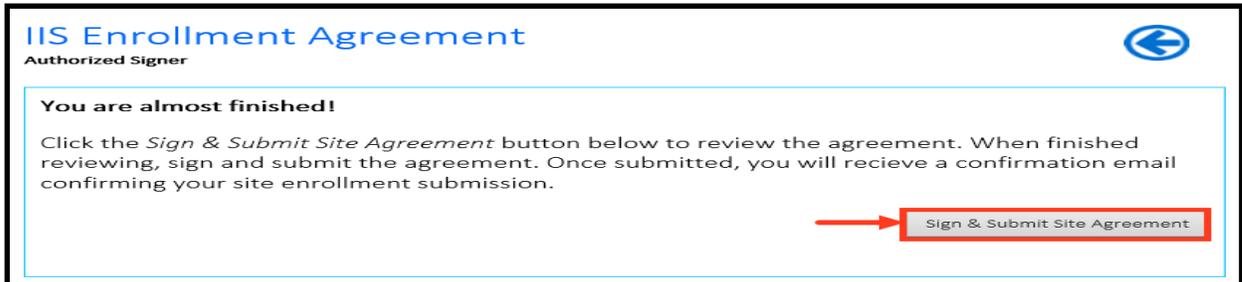
In the signature portal, enter the unique signature code included in the email and select **Validate Code**; then select **Continue**. See *Figure 24: Instructions for Electronic Signature*.



Figure 24: Instructions for Electronic Signature

Sign & Submit Site Agreement.

On the next page, select **Sign & Submit Site Agreement**. See *Figure 25: Sign & Submit Site Agreement*.



IIS Enrollment Agreement

Authorized Signer

You are almost finished!

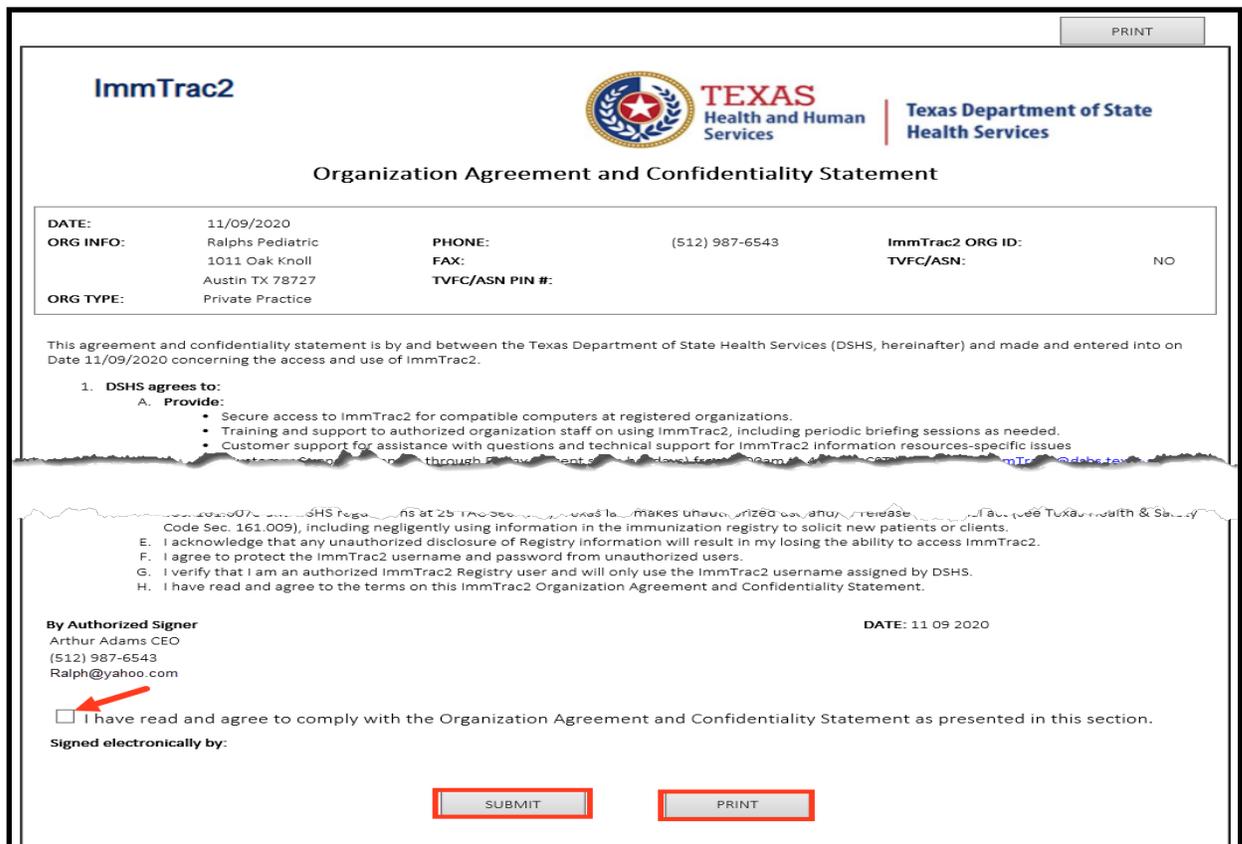
Click the *Sign & Submit Site Agreement* button below to review the agreement. When finished reviewing, sign and submit the agreement. Once submitted, you will receive a confirmation email confirming your site enrollment submission.

Sign & Submit Site Agreement

Figure 25: Sign & Submit Site Agreement

Organization Agreement and Confidentiality Statement.

Carefully read through the ImmTrac2 Organization Agreement and Confidentiality Statement. Then select the box at the bottom. See *Figure 26: ImmTrac2 Organization Agreement and Confidentiality Statement*.



ImmTrac2

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Organization Agreement and Confidentiality Statement

DATE:	11/09/2020	PHONE:	(512) 987-6543	ImmTrac2 ORG ID:	
ORG INFO:	Ralphs Pediatric 1011 Oak Knoll Austin TX 78727	FAX:		TVFC/ASN:	NO
ORG TYPE:	Private Practice	TVFC/ASN PIN #:			

This agreement and confidentiality statement is by and between the Texas Department of State Health Services (DSHS, hereinafter) and made and entered into on Date 11/09/2020 concerning the access and use of ImmTrac2.

1. DSHS agrees to:

A. Provide:

- Secure access to ImmTrac2 for compatible computers at registered organizations.
- Training and support to authorized organization staff on using ImmTrac2, including periodic briefing sessions as needed.
- Customer support for assistance with questions and technical support for ImmTrac2 information resources-specific issues

B. I acknowledge that any unauthorized disclosure of Registry information will result in my losing the ability to access ImmTrac2.

C. I agree to protect the ImmTrac2 username and password from unauthorized users.

D. I verify that I am an authorized ImmTrac2 Registry user and will only use the ImmTrac2 username assigned by DSHS.

E. I have read and agree to the terms on this ImmTrac2 Organization Agreement and Confidentiality Statement.

By Authorized Signer
Arthur Adams CEO
(512) 987-6543
Ralph@yahoo.com

DATE: 11 09 2020

I have read and agree to comply with the Organization Agreement and Confidentiality Statement as presented in this section.

Signed electronically by:

SUBMIT **PRINT**

Figure 26: Immtrac2 Organization Agreement and Confidentiality Statement

A new window will appear. Select **I Accept**. See *Figure 27: Electronic Signature Agreement*.



Figure 27: Electronic Signature Agreement

Then select **Submit**. See *Figure 28: Submit Electronic Signature*.



Figure 28: Submit Electronic Signature

Congratulations! The ImmTrac2 Registration has been successfully submitted! Please allow 10-14 business days for processing. Select **Begin COVID-19 Provider Enrollment** to proceed to the Pandemic Provider Enrollment. See *Figure 29: ImmTrac2 Registration Request has been Received*.

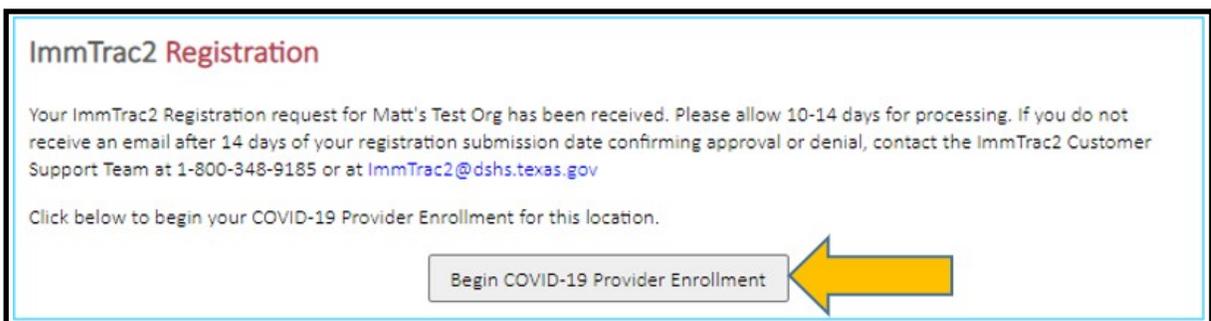


Figure 29: ImmTrac2 Registration Request has been Received

Part B: Pandemic Provider Enrollment

Intro to the Pandemic Provider Enrollment Process

Our recommended browser is Google Chrome. See *Figure 30: Chrome Icon*.



Figure 30: Chrome Icon

When completing the Pandemic Provider Enrollment, organizations that oversee multiple facilities MUST complete an individual enrollment for each site that plans on storing and administering the COVID-19 Vaccine. Each facility account must also use a different email when completing the required fields in [Step A4: Your Information](#) to avoid repopulating the fields with another facility's information.

All organizations will need to provide the following information to complete the Pandemic Provider Enrollment:

- Organization information:
 - Name
 - Physical and mailing address
 - Phone number
 - Fax number
- Primary and Secondary site contact:
 - First and last name
 - Phone number
 - Email address for each person
- Fridge/Freezer/Ultra-Cold Storage capability:
 - Make/model
 - Cubic feet
- Data logger information:
 - Make/model
 - Expiration date-locked to only future dates
 - Certificate of Calibration for each data logger
- Prescribing Providers:
 - First and last name
 - Phone number
 - License number
 - TPI
 - NPI
 - Medicaid ID
 - Specialty
- Patient population

In *Figure 31: Info Needed for Pandemic Provider Enrollment*, providers see the information they will need and have one of two choices:

1. To enroll as a pandemic provider, select the **Enroll Now** button at the bottom of the form and continue to the "[Location and Shipping](#)" section.
2. To skip the Pandemic Provider Enrollment, select the **SKIP** button and go back to the "Get Started" screen (see *Figure 32: Get Started Screen*). By selecting the SKIP button, you have not completed the pandemic enrollment and can later select "Click to Start Pandemic Provider Enrollment" to continue enrollment.



PANDEMIC PROVIDER ENROLLMENT

Enroll to request COVID-19 Vaccine

✕

In order to receive COVID-19 vaccine, you must enroll with Texas DSHS.

You will need to provide the following information to complete enrollment.

- Confirm location and shipping address
- Provide days and times of the week when shipments of vaccine can be received.
- PLEASE NOTE:** You **MUST HAVE** at least one (1) day other than a Monday, which has a four (4) hour designated window for delivery of your vaccine shipment. For example: Thursday 8am to 12pm.

Proof of Vaccine Storage Capacity (On site refrigeration and freezer appliances)

Information needed for each appliance:

- Storage Unit Location (within the facility)
- Brand and Model
- Storage Capacity (cubic feet)
- Use [Primary, Backup/Overflow, Day Use]
- Refrigerator Type [Under the counter (freezerless), Standalone (freezerless), Combination (Single Control), Combination (Dual Control), Other]
- Refrigerator Grade [Household, Commercial, Medical/Laboratory/Pharmaceutical]
- Freezer Type [Standalone Upright, Standalone Chest, Combination (Single Control), Combination (Dual Control), Other]
- Freezer Grade [Household, Commercial, Medical/Laboratory/Pharmaceutical]

Needed Data Logger Information (for refrigerators, freezer and backup freezer data logger)

- Data Logger Type [Built-In, Digital Data Logger (WiFi), Digital Data Logger (Wired), Other]
- Brand and Model
- Serial Number
- Calibration Expiration Date [Proof for each Data Logger of a calibration certificate not expiring within 60 days of submitting your enrollment request.]

Vaccine Administering Capacity

- This is the number of medical practitioners currently licensed in the state of Texas working in the facility who have Prescribing Authority.

Patient Profile

- Information pertaining to the current patients served in the facility. (ex. Children, Adults and high-risk categories.)

Enroll Now

SKIP

Figure 31: Info Needed for Pandemic Provider Enrollment



David.Disney1

<p>Facility Information</p> <p>Pauls Pediatric Practice DBA: 1101 W. 49th Sgstreet, Austin, TX 78756 Travis Phone: (512) 345-6789</p>	<p>Facility Type: Private Practice Facility NPI: Manner of Usage: Direct Entry <input checked="" type="checkbox"/> IIS: PAUL1931 <input type="checkbox"/> TVFC/ASN PIN: <input type="checkbox"/> Pandemic: Not Started</p>	<p>My Profile</p> <p>David Disney Phone: (512) 345-6789 Email: YourEmail@gmail.com</p>
--	--	---

Get Started . . .

Click below to complete tasks to finish setting up your clinic's account.

<p style="color: blue; font-size: 1.1em; margin: 5px 0;">Policy Documents</p> <p style="font-size: 0.9em; margin: 5px 0;">Complete & Submit required forms.</p> <p style="color: green; font-size: 0.8em; margin: 5px 0;"><input checked="" type="checkbox"/> ImmTrac2 Org Agreement</p>	<p style="color: blue; font-size: 1.1em; margin: 5px 0;">Texas Vaccines for Children and Adult Safety Net Program</p> <p style="color: red; font-size: 1.1em; margin: 10px 0;">Coming soon...</p>	<p style="color: blue; font-size: 1.1em; margin: 5px 0;">PANDEMIC PROVIDER ENROLLMENT</p> <p style="font-size: 0.9em; margin: 5px 0;">Enroll as Pandemic Provider to request COVID-19 Vaccine</p> <div style="border: 2px solid red; padding: 5px; width: fit-content; margin: 10px auto; color: red; font-size: 0.9em;"> <p style="margin: 0;">Click to Start Pandemic Provider Enrollment</p> </div>
---	--	--

Figure 32: "Get Started" Screen

Step B1: Location and Shipping.

Please fill out all required fields, marked with an asterisk, with the most recent and accurate information (see *Figure 33: Location and Shipping*). If "Shipping Address" is the same as "Location Where Vaccine will be Administered", please select the appropriate boxes.

When prompted, "**Will another organization location order COVID-19 Vaccine for this site?**" we highly recommend selecting "No".

If there is a circumstance in which the facility under this account might have to order from another organization, please phone 877-835-7750 or send an email to COVID19VacEnroll@dshs.texas.gov.

After reviewing, select **Save & Continue** or click **Save & Exit** to enter the next section.

Location and Shipping





PANDEMIC PROVIDER ENROLLMENT

Enroll to request COVID-19 Vaccine

Location and Shipping address
Confirm the physical address on file below

*Facility Name	Pauls Fourteenth Pediatric Practice	TVFC/ASN PIN #	
*Facility Address	1100 W. 49th	Suite #	
*City	Austin		
*State	Texas	*Zip	78756
*County	TRAVIS	*Country	United States
Telephone*	512 345 6789	Fax	

*Will another organization location order COVID-19 Vaccine for this site? Yes No

Shipping Address
Please provide the address of location where vaccine inventory should be shipped to.

Same as physical address above

Shipping Address	Suite #
City	
State	Texas
County	
	United States

Address of Location Where Vaccine will be Administered
Please provide the address of the location where vaccine will be administered to the patients.

Same as physical address above

Address	Suite #
City	
State	
County	
	Country

Figure 33: Location and Shipping

Step B2: Pandemic Vaccine Coordinators.

Provide names and contact information for both Primary and Secondary Vaccine Coordinators. After reviewing, you may **Save and Continue** or **Save and Exit**.

Primary and Backup Vaccine Coordinators

Organizations must assign a Primary Vaccine Coordinator and a Backup Vaccine Coordinator (See *Figure 34: Primary and Backup Vaccine Coordinators*). They will be the Point of Contact for vaccine distribution, accountability, and communications as well as be responsible for safe storage and handling of the COVID-19 Vaccine. These roles cannot be filled by the same person.

Note: Texas Department of State Health Services strongly encourages all primary and backup vaccine coordinators to take the CDC's training "Module 10: You Call the Shots: Storage and Handling" found at <https://www2a.cdc.gov/nip/isd/ycts/mod1/courses/sh/ce.asp>. The certificates of completion for the training module must be kept onsite and readily available in accordance with the CDC COVID-19 record retention requirement of three years.

<ul style="list-style-type: none"> <li style="border: 1px solid #ccc; padding: 2px; margin-bottom: 2px;">Location and Shipping <li style="border: 1px solid #ccc; padding: 2px; margin-bottom: 2px; background-color: #e0f0ff;">Pandemic Vaccine Coordinators <li style="border: 1px solid #ccc; padding: 2px; margin-bottom: 2px;">Delivery Times <li style="border: 1px solid #ccc; padding: 2px; margin-bottom: 2px;">Vaccine Storage Capacity <li style="border: 1px solid #ccc; padding: 2px; margin-bottom: 2px;">Prescribing Providers <li style="border: 1px solid #ccc; padding: 2px; margin-bottom: 2px;">Patient Profile <li style="border: 1px solid #ccc; padding: 2px; margin-bottom: 2px;">Administration and Reporting <li style="border: 1px solid #ccc; padding: 2px; margin-bottom: 2px;">Responsible Officers <li style="border: 1px solid #ccc; padding: 2px; margin-bottom: 2px;">Provider Agreements 	<div style="text-align: center;">  <h2 style="margin: 0;">PANDEMIC PROVIDER ENROLLMENT</h2> <p style="margin: 0; color: #c00000;">Enroll to request COVID-19 Vaccine</p> </div> <hr/> <p>Pandemic Vaccine Coordinators Designate the primary and backup pandemic vaccine coordinators for this facility. The coordinators will become the main point-of-contact for vaccine distribution, accountability and other communications.</p> <div style="border: 1px solid #add8e6; padding: 5px; margin-bottom: 10px;"> <p>Primary Vaccine Coordinator</p> <p>*Last Name <input style="width: 150px;" type="text"/> *First Name <input style="width: 150px;" type="text"/> MI <input style="width: 30px;" type="text"/></p> <p>*Telephone <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> x <input style="width: 40px;" type="text"/> *Email <input style="width: 180px;" type="text"/></p> <p>Degree/Credentials <input style="width: 150px;" type="text"/></p> </div> <div style="border: 1px solid #add8e6; padding: 5px;"> <p>Backup Vaccine Coordinator</p> <p>*Last Name <input style="width: 150px;" type="text"/> *First Name <input style="width: 150px;" type="text"/> MI <input style="width: 30px;" type="text"/></p> <p>*Telephone <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> <input style="width: 40px;" type="text"/> x <input style="width: 40px;" type="text"/> *Email <input style="width: 180px;" type="text"/></p> <p>Degree/Credentials <input style="width: 150px;" type="text"/></p> </div> <div style="text-align: right; margin-top: 10px;"> <input type="button" value="Save & Continue"/> <input type="button" value="Save & Exit"/> </div>
---	---

Figure 34: Primary and Backup Vaccine Coordinators

Step B3: Delivery Times.

Provide dates and times when the vaccine can be delivered to the facility and any special instructions for vaccine delivery if necessary. See *Figure 35: Delivery Times*. After reviewing the fields, you may **Save & Continue** or **Save & Exit**.

Note: The facility MUST have at least one weekday, other than Monday, which has a four-hour designated window for delivery of vaccine shipment (*for example: Thursday 8am-12pm*).

[Location and Shipping](#) ✓

[Pandemic Vaccine Coordinators](#) ✓

[Delivery Times](#) ✓

Vaccine Storage Capacity ⓪

Prescribing Providers ⓪

Patient Profile ⓪

Administration and Reporting ⓪

Responsible Officers ⓪

Provider Agreements ⓪



PANDEMIC PROVIDER ENROLLMENT

Enroll to request COVID-19 Vaccine

Delivery Times

Provide days and times of the week when shipments of vaccine can be received. A break is provided to notate hours closed for lunches. If the additional block is not needed, notate the availability within the first section for each day provided.

PLEASE NOTE: You **MUST HAVE** at least one (1) weekday other than a Monday, which has a four (4) hour designated window for delivery of your vaccine shipment. For example: Thursday 8am to 12pm.

Provide the times of day during the week when vaccine can be delivered to the facility.

Monday	From Time 1	Through Time 1	From Time 2	Through Time 2
Tuesday	▼	▼	▼	▼
Wednesday	▼	▼	▼	▼
Thursday	▼	▼	▼	▼
Friday	▼	▼	▼	▼
Saturday	▼	▼	▼	▼
Sunday	▼	▼	▼	▼

Provide any special instructions for vaccine delivery

Figure 35: Delivery Times



Step B4: Vaccine Storage Capacity.

Refrigerators

Select "Yes" or "No" under Vaccine Storage Capacity if your facility has the capacity to store additional REFRIGERATED vaccine at a temperature range of 2°C to 8°C (36°F to 46°F). See *Figure 36: Vaccine Storage Capacity*.

- If you choose "**Yes**":
You will be prompted to answer questions about the refrigerator and data logger. Provide information about refrigerators used to store vaccine in your facility. Give information about each data logger in your facility - type, serial number, calibration expiration date, brand, and model. After reviewing the fields, choose **Save** or **Save and Exit**.

If you have additional refrigeration, add those refrigerators and their respective information. If no additional refrigeration, click **Continue** and proceed.

Note: The CDC recommends the following vaccine storage unit types (in order of preference) for refrigerator use for vaccines:

- Pharmaceutical grade storage unit (preferred),
- Household or commercial grade stand-alone units, or
- Household combination units using the refrigerator section only.

It is not required to have a separate refrigerator for the COVID-19 Vaccine. However, the COVID-19 Vaccine **must** have its own separate shelf that is clearly labeled.

Note: Each kit ordered will have 100 doses as well as ancillary supplies within the shipment.

- If you choose "**No**", you will be taken to the next screen.



Location and Shipping
✓

Pandemic Vaccine Coordinators
✓

Delivery Times
✓

Vaccine Storage Capacity
🔄

Prescribing Providers
🔒

Patient Profile
🔒

Administration and Reporting
🔒

Responsible Officers
🔒

Provider Agreements
🔒

PANDEMIC PROVIDER ENROLLMENT

Enroll to request COVID-19 Vaccine

Vaccine Storage Capacity

REFRIGERATORS

ESTIMATED NUMBER OF 10-DOSE MULTIDOSE VIALS (MDVs) YOUR LOCATION IS ABLE TO STORE DURING PEAK VACCINATION PERIODS (E.G., DURING BACK-TO-SCHOOL OR INFLUENZA VACCINE SEASON) AT THE FOLLOWING TEMPERATURES:

***Do you have the capacity to store additional REFRIGERATED at a temperature range of 2° C to 8° C?** Yes No

*Approximately how many additional 10-dose MDVs can you store at this temperature?

Provide information about refrigerators used to store vaccine in this facility

*Storage Unit Location	<input style="width: 90%;" type="text"/>	*Brand & Model	<input style="width: 90%;" type="text"/>
*Storage Capacity (in cubic feet)	<input style="width: 90%;" type="text"/>	*Use	<input style="width: 90%;" type="text"/>
*Refrigerator Type	<input style="width: 90%;" type="text"/>	if Other Specify	<input style="width: 90%;" type="text"/>
*Refrigerator Grade	<input style="width: 90%;" type="text"/>		

Data Logger Information:

*Data Logger Type	<input style="width: 90%;" type="text"/>	if Other Specify	<input style="width: 90%;" type="text"/>
*Data Logger Brand & Model	<input style="width: 90%;" type="text"/>	*Data Logger Serial Number	<input style="width: 90%;" type="text"/>

*Calibration Expiration Date (XX-XX-XXXX): / /

ADDITIONAL REFRIGERATORS

+ Add Another Refrigerator

#	Storage Unit Location	Brand & Model	Storage Capacity (in cubic feet)	Use	Edit
No Records Found.					

Figure 36: Vaccine Storage Capacity

Freezers

Select “**Yes**” or “**No**” if your facility has the capacity to store FROZEN vaccine at a temperature range of -25°C to -15°C (-13°F to 5°F).

- If you choose “**Yes**”, you will be prompted to answer questions about the freezer, data logger and back-up data logger (see *Figure 37: Freezers*). Provide information about freezers used to store vaccine in your facility. Give information about each data logger in your facility - type, serial number, calibration expiration date, brand, and model. After reviewing, select **Save** or **Save and Exit**.

If you have additional freezers, add those freezers and their respective information. If none, proceed and **Continue**.

- If you choose **No**, you will be taken to the next screen.

[Location and Shipping](#) ✓

[Pandemic Vaccine Coordinators](#) ✓

[Delivery Times](#) ✓

[Vaccine Storage Capacity](#) ✓

[Prescribing Providers](#) ⓧ

[Patient Profile](#) ⓧ

[Administration and Reporting](#) ⓧ

[Responsible Officers](#) ⓧ

[Provider Agreements](#) ⓧ



PANDEMIC PROVIDER ENROLLMENT

Enroll to request COVID-19 Vaccine

Vaccine Storage Capacity

FREEZERS

ESTIMATED NUMBER OF 10-DOSE MULTIDOSE VIALS (MDVs) YOUR LOCATION IS ABLE TO STORE DURING PEAK VACCINATION PERIODS (E.G., DURING BACK-TO-SCHOOL OR INFLUENZA VACCINE SEASON) AT THE FOLLOWING TEMPERATURES:

*Do the facility have the capacity to store Frozen vaccine at a temperature range of -15° C to -25° C? Yes No

*Approximately how many additional FROZEN 10-dose MDVs can you store at this temperature?

Provide information about freezers used to store vaccine in this facility

*Storage Unit Location	<input type="text"/>	*Brand & Model	<input type="text"/>
*Storage Capacity (in cubic feet)	<input type="text"/>	*Use	<input type="text"/>
*Freezer Type	<input type="text"/>	if Other Specify	<input type="text"/>
*Freezer Grade	<input type="text"/>		

Data Logger Information:

*Data Logger Type	<input type="text"/>	if Other Specify	<input type="text"/>
*Data Logger Brand & Model	<input type="text"/>	*Data Logger Serial Number	<input type="text"/>
*Calibration Expiration Date (XX-XX-XXXX):	<input type="text"/>		

Indicate information for your BACKUP Data Logger below:

*Data Logger Type	<input type="text"/>	if Other Specify	<input type="text"/>
*Data Logger Brand & Model	<input type="text"/>	*Data Logger Serial Number	<input type="text"/>
*Calibration Expiration Date (XX-XX-XXXX):	<input type="text"/>		

Figure 37: Freezers



Ultra-Cold Freezers

Select **Yes** or **No** if your facility has the capacity to store ULTRA-FROZEN vaccine at a temperature range of -80°C to -60°C (-112°F to -76°F). See *Figure 38: Ultra-Cold Freezers*.

- If you choose **Yes**, you will be prompted to answer questions about the ultra-cold freezer, data logger, and back-up data logger such as type, serial number, calibration expiration date, brand, and model. Provide information about ultra-code freezers used to store vaccine in your facility. After reviewing, select **Save** or **Save and Exit**.

If you have additional ultra-cold freezers, add those ultra-cold freezers and their respective information. If none, proceed and **Continue**.

- If you choose **No**, you will be taken to the next screen.

PANDEMIC PROVIDER ENROLLMENT
Enroll to request COVID-19 Vaccine

Vaccine Storage Capacity

ULTRA-COLD FREEZERS
ESTIMATED NUMBER OF 10-DOSE MULTIDOSE VIALS (MDVs) YOUR LOCATION IS ABLE TO STORE DURING PEAK VACCINATION PERIODS (E.G., DURING BACK-TO-SCHOOL OR INFLUENZA VACCINE SEASON) AT THE FOLLOWING TEMPERATURES:

*Do the facility have the capacity to store Ultra-frozen vaccine at a temperature range of -60° C to -80° C? Yes No

*Approximately how many additional ULTRA-FROZEN 10-dose MDVs can you store at this temperature?

Provide information about ultra-cold freezers used to store vaccine in this facility

*Storage Unit Location	<input type="text"/>	*Brand & Model	<input type="text"/>
*Storage Capacity (in cubic feet)	<input type="text"/>	*Use	<input type="text"/>
*Freezer Type	<input type="text"/>	if Other Specify	<input type="text"/>
*Freezer Grade	<input type="text"/>		

Data Logger Information:

*Data Logger Type	<input type="text"/>	if Other Specify	<input type="text"/>
*Data Logger Brand & Model	<input type="text"/>	*Data Logger Serial Number	<input type="text"/>
*Calibration Expiration Date (XX-XX-XXXX):	<input type="text"/>		

Indicate information for your BACKUP Data Logger below:

*Data Logger Type	<input type="text"/>	if Other Specify	<input type="text"/>
*Data Logger Brand & Model	<input type="text"/>	*Data Logger Serial Number	<input type="text"/>
*Calibration Expiration Date (XX-XX-XXXX):	<input type="text"/>		

Buttons: Save, Save & Exit

ADDITIONAL ULTRA-COLD FREEZERS + Add Another Ultra-Cold Freezer

#	Storage Unit Location	Brand & Model	Storage Capacity (in cubic feet)	Use	Edit
No Records Found.					

Continue

Figure 38: Ultra-Cold Freezers

Data-Logger Calibration Certificates

The **Data Logger** page should populate with data logger information you previously identified in use for your location. Read instructions 1-4 carefully to efficiently upload calibration certificates. See *Figure 39: Data Logger Calibration Certificates*.

Click **Continue** after certificate(s) is/are uploaded. It is recommended to place the enrollment on hold until a calibration certificate is uploaded by selecting **Save & Exit**.

- Location and Shipping ✓
- Pandemic Vaccine Coordinators ✓
- Delivery Times ✓
- Vaccine Storage Capacity ✓
- Prescribing Providers 🔄
- Patient Profile 🔒
- Administration and Reporting 🔒
- Responsible Officers 🔒
- Provider Agreements 🔒



PANDEMIC PROVIDER ENROLLMENT

Enroll to request COVID-19 Vaccine

Data Logger - Calibration Certificates

Below are the data loggers you have identified in use your location. Please upload a scanned copy of the certificate for each to confirm date calibration and expiration.

Instructions:

1. Save a digital image (.pdf, .bmp, .jpg, .jpeg, .tif, .tiff, or .png file types allowed) of each calibration certificate to your computer, identifying it by serial number.
2. Locate the coinciding serial number in the below list and click browse.
3. Select the calibration certificate file with the same serial number from your computer.
4. Click upload to load the certificate.

Repeat steps 1 through 4 above until all certificates have been uploaded for your location. Click continue to resume the enrollment process.

#	Data Logger Brand & Model	Serial Number	Select Certificate	Upload	Certificate Uploaded?
1	LogiTech - Reliant	432536765	<input type="text" value="Browse..."/>	<input type="button" value="Upload"/>	✓
2	Logitech - Reliant	12543654	<input type="text" value="Browse..."/>	<input type="button" value="Upload"/>	✓

Figure 39: Data Logger Calibration Certificates

Step B5: Prescribing Providers.

Enter all healthcare providers in the facility you are registering who have prescription writing privileges. See *Figure 40: Prescribing Providers – Current Provider List*. You may use the **Upload Provider List** to upload multiple names at once. Review that all information for each provider is accurate.

Note: Do not include names of all staff who may administer the vaccine. This page is only for providers with prescription writing authority.

[Location and Shipping](#) ✓

[Pandemic Vaccine Coordinators](#) ✓

[Delivery Times](#) ✓

[Vaccine Storage Capacity](#) ✓

[Prescribing Providers](#) ✓

[Patient Profile](#) ⓧ

[Administration and Reporting](#) ⓧ

[Responsible Officers](#) ⓧ

[Provider Agreements](#) ⓧ



PANDEMIC PROVIDER ENROLLMENT

Enroll to request COVID-19 Vaccine

Prescribing Providers

Enter Provider Information

Use this page to list all health care providers at your facility with prescription writing privileges who will administer VFC Program-provided vaccines. Note: It is not necessary to include the names of all staff who may administer VFC vaccine, but rather only those who possess a medical license or are authorized to write prescriptions.

Current Provider List

#	Last Name	First Name	MI	Title	Specialty	License #	Medicaid #	NPI #	EIN	Edit	Remove
1	Spock	Paul		MD (Doctor of Medicine)	Pediatrics/Adolescent	N1234		1234567890		Edit	

Add Provider

Upload Provider List

Cancel

Save & Continue

Save & Exit

Figure 40: Prescribing Providers - Current Provider List

Texas Department of State Health Services
Immunization Unit

Stock No. 11-15952
Rev. 1/2021

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Step B6: Patient Profile.

Please select the best description of the registering facility from the options provided (See *Figure 41: Patient Profile Top Half* and *Figure 42: Patient Profile Bottom Half*). Provide the total count of patients being served in the facility within the past calendar year. Only one patient should be counted in the “total count of patients being served” even if they have had multiple visits to the facility or if they have received multiple vaccines.

Review the questions and select **Yes** on the populations your facility serves. Use records from the previous calendar year to answer the drop-down questions.

Note: “Peak Week” refers to the week when dose administration for the influenza vaccine reached its highest during 19-20 season. This week differs among facilities.

After reviewing the fields, select **Save and Continue** or **Save and Exit**.

Location and Shipping ✓	<div style="text-align: center;">  <h3>PANDEMIC PROVIDER ENROLLMENT</h3> <p>Enroll to request COVID-19 Vaccine</p> <hr/> <h4>Patient Profile</h4> <p style="text-align: right;">*Select the best description of this facility</p> <div style="border: 1px solid black; width: 100%; height: 20px; margin-bottom: 5px;"></div> <p>Provide the information requested below to identify the patient served at this location.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">*What is the total count of patients being served in this facility?</td> <td style="padding: 5px; text-align: right;"><input type="text" value="0"/></td> </tr> <tr> <td style="padding: 5px;">*Do you know the number of unique patients/clients seen per week, on average?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td style="padding: 5px;">*Do you know the number of influenza vaccine doses administered during the peak week of the 2019–20 influenza season?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td style="padding: 5px;">*Does your facility serve military patients that are active duty/reserves?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td style="padding: 5px;">*Does your facility serve pediatric patients?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td style="padding: 5px;">*Does your facility serve adult patients?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td style="padding: 5px;">*Does your facility serve adults 65 years of age and older?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td style="padding: 5px;">*Does your facility provide care to patients in long term care facilities (nursing home, assisted living or independent living facility)?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td style="padding: 5px;">*Does your facility serve health care workers?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td style="padding: 5px;">*Does your facility serve critical infrastructure/essential workers (e.g., education, law enforcement, food/agricultural workers, fire services)?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> <tr> <td style="padding: 5px;">*Does your facility serve patients experiencing homelessness?</td> <td style="padding: 5px; text-align: right;"><input type="radio"/> Yes <input type="radio"/> No</td> </tr> </table> </div>	*What is the total count of patients being served in this facility?	<input type="text" value="0"/>	*Do you know the number of unique patients/clients seen per week, on average?	<input type="radio"/> Yes <input type="radio"/> No	*Do you know the number of influenza vaccine doses administered during the peak week of the 2019–20 influenza season?	<input type="radio"/> Yes <input type="radio"/> No	*Does your facility serve military patients that are active duty/reserves?	<input type="radio"/> Yes <input type="radio"/> No	*Does your facility serve pediatric patients?	<input type="radio"/> Yes <input type="radio"/> No	*Does your facility serve adult patients?	<input type="radio"/> Yes <input type="radio"/> No	*Does your facility serve adults 65 years of age and older?	<input type="radio"/> Yes <input type="radio"/> No	*Does your facility provide care to patients in long term care facilities (nursing home, assisted living or independent living facility)?	<input type="radio"/> Yes <input type="radio"/> No	*Does your facility serve health care workers?	<input type="radio"/> Yes <input type="radio"/> No	*Does your facility serve critical infrastructure/essential workers (e.g., education, law enforcement, food/agricultural workers, fire services)?	<input type="radio"/> Yes <input type="radio"/> No	*Does your facility serve patients experiencing homelessness?	<input type="radio"/> Yes <input type="radio"/> No
*What is the total count of patients being served in this facility?		<input type="text" value="0"/>																					
*Do you know the number of unique patients/clients seen per week, on average?		<input type="radio"/> Yes <input type="radio"/> No																					
*Do you know the number of influenza vaccine doses administered during the peak week of the 2019–20 influenza season?		<input type="radio"/> Yes <input type="radio"/> No																					
*Does your facility serve military patients that are active duty/reserves?		<input type="radio"/> Yes <input type="radio"/> No																					
*Does your facility serve pediatric patients?		<input type="radio"/> Yes <input type="radio"/> No																					
*Does your facility serve adult patients?		<input type="radio"/> Yes <input type="radio"/> No																					
*Does your facility serve adults 65 years of age and older?		<input type="radio"/> Yes <input type="radio"/> No																					
*Does your facility provide care to patients in long term care facilities (nursing home, assisted living or independent living facility)?		<input type="radio"/> Yes <input type="radio"/> No																					
*Does your facility serve health care workers?		<input type="radio"/> Yes <input type="radio"/> No																					
*Does your facility serve critical infrastructure/essential workers (e.g., education, law enforcement, food/agricultural workers, fire services)?	<input type="radio"/> Yes <input type="radio"/> No																						
*Does your facility serve patients experiencing homelessness?	<input type="radio"/> Yes <input type="radio"/> No																						
Pandemic Vaccine Coordinators ✓																							
Delivery Times ✓																							
Vaccine Storage Capacity ✓																							
Prescribing Providers ✓																							
Patient Profile ✓																							
Administration and Reporting ⊘																							
Responsible Officers ⊘																							
Provider Agreements ⊘																							

Figure 41: Patient Profile - Top Half

*Does your facility serve pregnant women?	<input type="radio"/> Yes <input type="radio"/> No
*Does your facility serve patients from ethnic minority groups?	<input type="radio"/> Yes <input type="radio"/> No
*Does your facility serve patients from tribal communities?	<input type="radio"/> Yes <input type="radio"/> No
*Does your facility serve patients who are incarcerated/detained?	<input type="radio"/> Yes <input type="radio"/> No
*Does your facility serve patients living in rural communities?	<input type="radio"/> Yes <input type="radio"/> No
*Does your facility serve under-insured or uninsured patients?	<input type="radio"/> Yes <input type="radio"/> No
*Does your facility serve patients with disabilities?	<input type="radio"/> Yes <input type="radio"/> No
*Does your facility serve military veterans?	<input type="radio"/> Yes <input type="radio"/> No
*Does your facility serve patients with underlying medical conditions that are risk factors for severe COVID-19 illness?	<input type="radio"/> Yes <input type="radio"/> No
* Does your facility serve other populations at higher-risk for COVID-19?	<input type="radio"/> Yes <input type="radio"/> No

Figure 42: Patient Profile Bottom Half

Step B7: Administration and Reporting.

Select all settings where your facility will be administering COVID-19. Select all that apply. See *Figure 43: Administration and Reporting*.

Select **Yes**, **No**, or **Not applicable** depending on your organization's current efforts to report vaccine administration data to the state, local, or territorial immunization information system. Identify in the open text box which way your facility has chosen to report data. After reviewing, you may **Save and Continue** or **Save and Exit**.

Note: Facilities are required to report each COVID-19 vaccine dose within 24 hours of administration per CDC guidelines.



Location and Shipping
✓

Pandemic Vaccine Coordinators
✓

Delivery Times
✓

Vaccine Storage Capacity
✓

Prescribing Providers
✓

Patient Profile
✓

Administration and Reporting
🔄

Responsible Officers
⊘

Provider Agreements
⊘

PANDEMIC PROVIDER ENROLLMENT

Enroll to request COVID-19 Vaccine

Administration and Reporting

SETTING(S) WHERE THIS LOCATION WILL ADMINISTER COVID-19 VACCINE (SELECT ALL THAT APPLY)

<input type="checkbox"/> Childcare or daycare facility <input type="checkbox"/> College, technical school, or university <input type="checkbox"/> Community center <input type="checkbox"/> Correctional/detention facility <input type="checkbox"/> Health care provider office, health center, medical practice, or outpatient clinic <input type="checkbox"/> Hospital (i.e., inpatient facility) <input type="checkbox"/> In-home <input type="checkbox"/> Long-term care facility (e.g., nursing home, assisted living, independent living, skilled nursing)	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Public health clinic (e.g., local health department) <input type="checkbox"/> School (K – grade 12) <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary or off-site vaccination clinic – point of dispensing (POD) <input type="checkbox"/> Temporary location – mobile clinic <input type="checkbox"/> Urgent care facility <input type="checkbox"/> Workplace <input type="checkbox"/> Other (specify)
--	---

***DOES YOUR ORGANIZATION CURRENTLY REPORT VACCINE ADMINISTRATION DATA TO THE STATE, LOCAL, OR TERRITORIAL IMMUNIZATION INFORMATION SYSTEM (IIS)?**

Yes
 No
 Not Applicable

**Please provide an explanation for the answer you provided above.*

Figure 43: Administration and Reporting

Step B8: Responsible Officers.

Identify your facility's Chief Medical Officer (CMO) and Chief Executive Officer (CEO). See *Figure 44: Responsible Officers*. They may be the same person if your facility operates as such. Populate all required fields ensuring that the email address listed for the individual(s) is/are correct. The identified parties will receive an email requesting their signature in the enrollment. After reviewing, select **Save and Continue** or **Save and Exit**.

Note: After signature requests are emailed, the enrollment will automatically lock until the review process is completed by Central Office. Until then, providers will not be able to update information as to prevent changes while in review.

Location and Shipping ✓	 <h3>PANDEMIC PROVIDER ENROLLMENT</h3> <p>Enroll to request COVID-19 Vaccine</p>
Pandemic Vaccine Coordinators ✓	
Delivery Times ✓	
Vaccine Storage Capacity ✓	
Prescribing Providers ✓	
Patient Profile ✓	
Administration and Reporting ✓	
Responsible Officers 🔄	
Provider Agreements 🔒	

Responsible Officers

FOR THE PURPOSES OF THIS AGREEMENT, IN ADDITION TO ORGANIZATION, RESPONSIBLE OFFICERS NAMED BELOW WILL ALSO BE ACCOUNTABLE FOR COMPLIANCE WITH THE CONDITIONS SPECIFIED IN THIS AGREEMENT. THE INDIVIDUALS LISTED BELOW MUST PROVIDE THEIR SIGNATURE AFTER REVIEWING THE AGREEMENT REQUIREMENTS.

Chief Medical Officer

Provide the **Chief Medical Officer** (Medical Director or Equivalent) below.

I am the Chief Medical Officer

*Last Name	<input type="text" value="Jones"/>	*First Name	<input type="text" value="Paul"/> MI <input type="text"/>
*Telephone	<input type="text" value="512"/> <input type="text" value="345"/> <input type="text" value="6789"/> x <input type="text"/>	*Email	<input type="text" value="YurName@gmail.com"/>
*License Type	<input type="text" value="MD (Doctor of Medicine)"/>	*Texas Medical Lic. #	<input type="text" value="N1234"/>
*Address	<input type="text"/>		
	Suite #	<input type="text"/>	
*City	<input type="text"/>		
*State	<input type="text" value="Texas"/>		
*County	<input type="text"/>		
	*Zip	<input type="text"/>	
	*Country	<input type="text" value="United States"/>	

Chief Executive Officer

Provide the **Chief Executive Officer** (or Chief Fiduciary) below.

I am the Chief Executive Officer (or Chief Fiduciary)

*Last Name	<input type="text"/>	*First Name	<input type="text"/> MI <input type="text"/>
*Telephone	<input type="text"/> <input type="text"/> <input type="text"/> x <input type="text"/>	*Email	<input type="text"/>
*Address	<input type="text"/>		
	Suite #	<input type="text"/>	
*City	<input type="text"/>		
*State	<input type="text" value="Texas"/>		
*County	<input type="text"/>		
	*Zip	<input type="text"/>	
	*Country	<input type="text" value="United States"/>	

Figure 44: Responsible Officers

Step B9: Provider Agreements.

After requests for signatures have been sent, you will have the opportunity to preview the agreement and print a copy for your safe keeping (see *Figure 45: Preview Provider Agreement*). We encourage you to print out a copy of the agreement for your office to reference back any information about the program.



Figure 45: Preview Provider Agreement

After clicking **Preview Agreement**, the CDC COVID-19 Vaccination Program Provider Agreement will appear and summarize the enrollment survey with your facility's information. See [Appendix B CDC COVID-19 Provider Agreement](#).

At this time, please review the survey responses and ensure that information provided is accurate. You may note these needed changes and update the fields after Central Office has completed its review process.

After reviewing the CDC COVID-19 Vaccination Program Provider Agreement, the enrollment will take you back to this page and indicate that the enrollment has been locked (see *Figure 46: Locked for Signatures*). It will stay locked until the review process is completed.

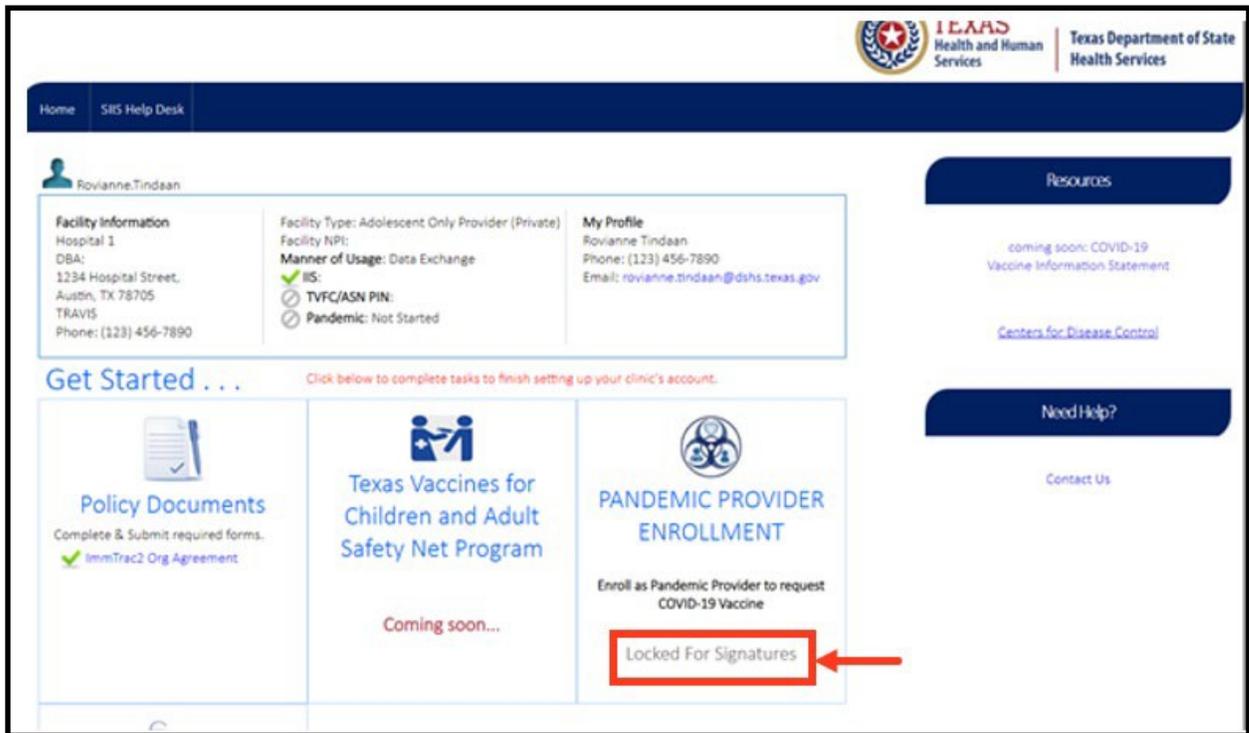


Figure 46: Locked for Signatures

On the next page is a sample signature request that signing authorities will receive (see *Figure 47: You Are the Authorized Individual to Sign*). Prompt the recipients to read through the instructions, click on the link, and electronically sign the form.

If you encounter errors, please forward them to the email address provided in the email signature and relay the issue. Please include screenshots if applicable.



Subject: COVID - 19 Vaccination Site Registration: Your action is needed.

Hello ksdvhur dkgvsj

You have been identified by fskjvh dlkcjlwk as the authorized individual from P1 to sign on behalf of the organization to enroll as a provider in the Texas COVID - 19 Vaccination response.

fskjvh dlkcjlwk has completed the required enrollment forms and they are now ready for your signature.

Instructions for electronic signature.

1. Click or copy / paste the link to the right in your web browser. <http://www.iv5uatcair2.com/SyntropiTXUAT/signPanAgreement.asp?code=8E96DF37EB>
2. Review the COVID-19 Vaccination Program Provider Agreement.
3. Apply your electronic Signature.

After you have completed signing you and fskjvh dlkcjlwk will receive a confirmation email. Once signed, your site enrollment request will be reviewed by the Texas Department of State Health Services Immunization Unit prior to approval.

If you have any questions, please contact the COVID-19 Provider Enrollment Customer Support Team.

Thank you,

COVID-19 Registration Support

Toll-Free: (877) 835-7750

COVID19VacEnroll@dshs.texas.gov



Figure 47: You Are the Authorized Individual to Sign



Appendix A. How to Check the Status of Your Registration

Log in to the Texas DSHS Immunization Portal with the credentials assigned during [Step A4: Your Information](#). See *Figure 48: Logging in to DSHS Immunization Portal*.

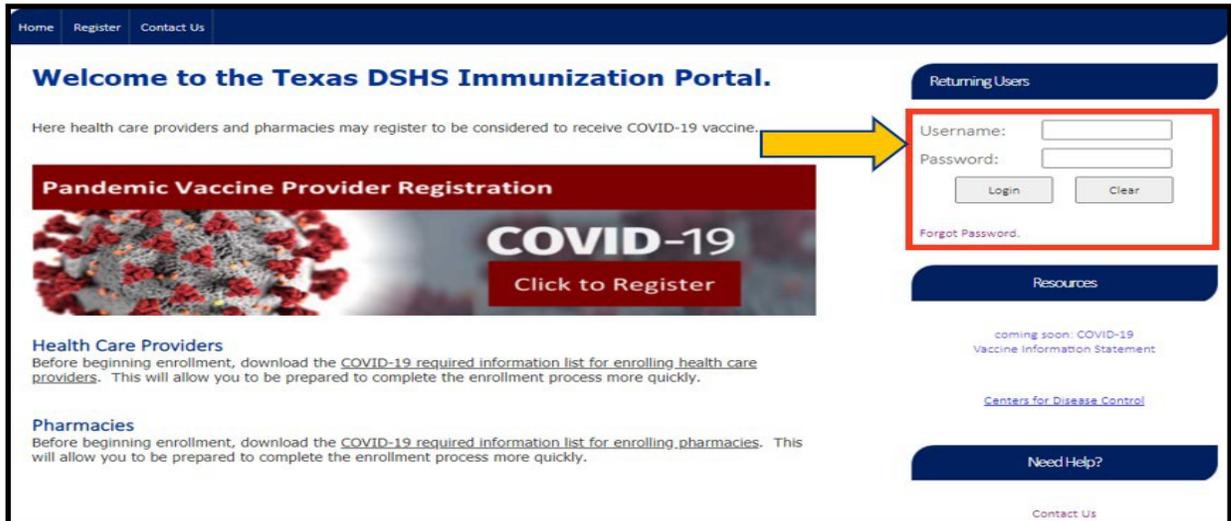


Figure 48: Logging in to DSHS Immunization Portal

Incomplete Registration

If you have not completed the ImmTrac2 registration or Pandemic Provider Enrollment, you will be taken to the first incomplete page after signing in.

Pending Signature Status

This status indicates that the ImmTrac2 registration has been submitted for signature but the Authorized Signer has not electronically signed the agreement.

See *Figure 49: Pending Signature*.



Figure 49: Pending Signature



Completed ImmTrac2 Registration but Pandemic Provider Enrollment Not Started

To continue the enrollment process, select the hyperlink **Click to Start Pandemic Provider Enrollment**. See *Figure 50: Start Pandemic Provider Enrollment*.

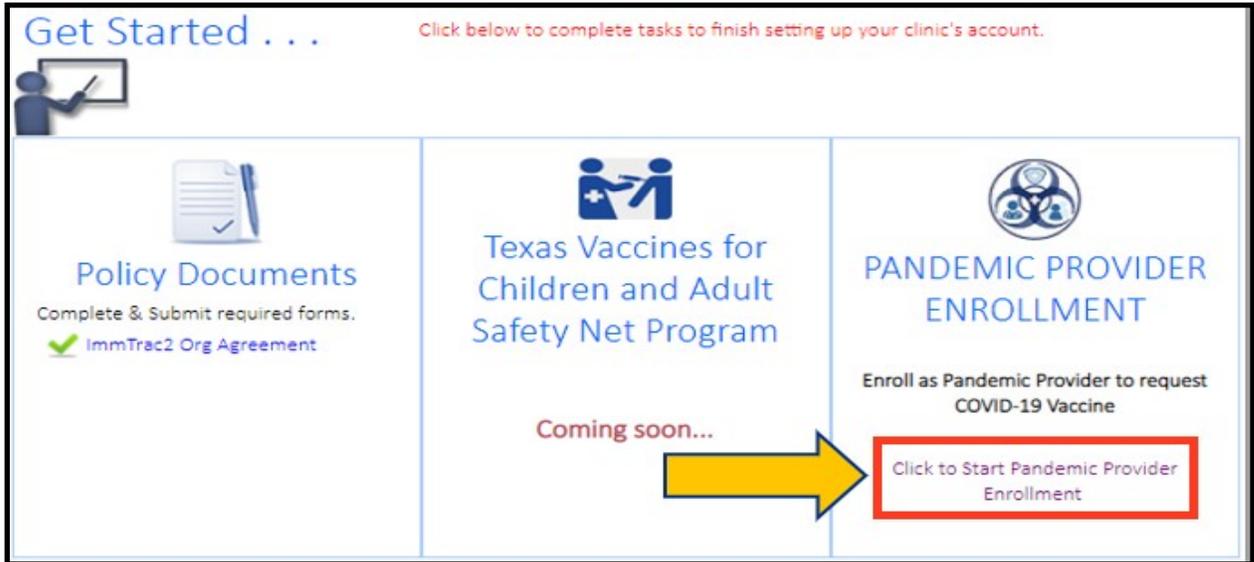


Figure 50: Start Pandemic Provider Enrollment



Appendix B. CDC COVID-19 Vaccination Program Provider Agreement

CDC COVID-19 Vaccination Program Provider Agreement



Please complete Sections A and B of this form as follows:

The Centers for Disease Control and Prevention (CDC) greatly appreciates your organization's (Organization) participation in the CDC COVID-19 Vaccination Program. Your Organization's chief medical officer (or equivalent) and chief executive officer (or chief fiduciary)—collectively, Responsible Officers—must complete and sign the CDC COVID-19 Vaccination Program Provider Requirements and Legal Agreement (Section A). CDC COVID-19 Vaccination Program Provider Profile Information (Section B) must be completed for each vaccination Location covered under the Organization listed in Section A.

Section A. COVID-19 Vaccination Program Provider Requirements and Legal Agreement

ORGANIZATION IDENTIFICATION		
Organization's legal name:		
Number of affiliated vaccination locations covered by this agreement: _____		
Organization telephone number:	Email (must be monitored and will serve as dedicated contact method for the COVID-19 Vaccination Program):	
Organization address:		
RESPONSIBLE OFFICERS		
For the purposes of this agreement, in addition to Organization, Responsible Officers named below will also be accountable for compliance with the conditions specified in this agreement. The individuals listed below must provide their signature after reviewing the agreement requirements.		
Chief Medical Officer (or Equivalent) Information		
Last name	First name	Middle initial
Title	Licensure (state and number)	
Telephone number:	Email:	
Address:		
Chief Executive Officer (or Chief Fiduciary) Information		
Last name	First name	Middle initial
Telephone number:	Email:	
Address:		

Figure 51: CDC COVID-19 Vaccination Program Provider Agreement – Page 1



CDC COVID-19 Vaccination Program Provider Agreement

AGREEMENT REQUIREMENTS

I understand this is an agreement between Organization and CDC. This program is a part of collaboration under the relevant state, local, or territorial immunization's cooperative agreement with CDC.

To receive one or more of the publicly funded COVID-19 vaccines (COVID-19 Vaccine), constituent products, and ancillary supplies at no cost, Organization agrees that it will adhere to the following requirements:

1.	Organization must administer COVID-19 Vaccine in accordance with all requirements and recommendations of CDC and CDC's Advisory Committee on Immunization Practices (ACIP). ¹
2.	<p>Within 24 hours of administering a dose of COVID-19 Vaccine and adjuvant (if applicable), Organization must record in the vaccine recipient's record and report required information to the relevant state, local, or territorial public health authority. Details of required information (collectively, Vaccine-Administration Data) for reporting can be found on CDC's website.²</p> <p>Organization must submit Vaccine-Administration Data through either (1) the immunization information system (IIS) of the state and local or territorial jurisdiction or (2) another system designated by CDC according to CDC documentation and data requirements.²</p> <p>Organization must preserve the record for at least 3 years following vaccination, or longer if required by state, local, or territorial law. Such records must be made available to any federal, state, local, or territorial public health department to the extent authorized by law.</p>
3.	Organization must not sell or seek reimbursement for COVID-19 Vaccine and any adjuvant, syringes, needles, or other constituent products and ancillary supplies that the federal government provides without cost to Organization.
4.	Organization must administer COVID-19 Vaccine regardless of the vaccine recipient's ability to pay COVID-19 Vaccine administration fees.
5.	Before administering COVID-19 Vaccine, Organization must provide an approved Emergency Use Authorization (EUA) fact sheet or vaccine information statement (VIS), as required, to each vaccine recipient, the adult caregiver accompanying the recipient, or other legal representative.
6.	Organization's COVID-19 vaccination services must be conducted in compliance with CDC's Guidance for Immunization Services During the COVID-19 Pandemic for safe delivery of vaccines. ³
7.	<p>Organization must comply with CDC requirements for COVID-19 Vaccine management. Those requirements include the following:</p> <ul style="list-style-type: none"> a) Organization must store and handle COVID-19 Vaccine under proper conditions, including maintaining cold chain conditions and chain of custody at all times in accordance with the manufacturer's package insert and CDC guidance in CDC's Vaccine Storage and Handling Toolkit⁴, which will be updated to include specific information related to COVID-19 Vaccine; b) Organization must monitor vaccine-storage-unit temperatures at all times using equipment and practices that comply with guidance located in CDC's Vaccine Storage and Handling Toolkit⁴; c) Organization must comply with each relevant jurisdiction's immunization program guidance for dealing with temperature excursions;

This agreement expressly incorporates all recommendations, requirements, and other guidance that this agreement specifically identifies through footnoted weblinks. Organization must monitor such identified guidance for updates. Organization must comply with such updates.

¹ <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

² <https://www.cdc.gov/vaccines/programs/iis/index.html>

³ <https://www.cdc.gov/vaccines/pandemic-guidance/index.html>

⁴ <https://www.cdc.gov/vaccines/hcp/admin/storage-handling.html>

Figure 52: CDC COVID-19 Vaccination Program Provider Agreement – Page 2



CDC COVID-19 Vaccination Program Provider Agreement

	d) Organization must monitor and comply with COVID-19 Vaccine expiration dates; and e) Organization must preserve all records related to COVID-19 Vaccine management for a minimum of 3 years, or longer if required by state, local, or territorial law.
8.	Organization must report the number of doses of COVID-19 Vaccine and adjuvants that were unused, spoiled, expired, or wasted as required by the relevant jurisdiction.
9.	Organization must comply with all federal instructions and timelines for disposing COVID-19 vaccine and adjuvant, including unused doses. ³
10.	Organization must report moderate and severe adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS). ⁶
11.	Organization must provide a completed COVID-19 vaccination record card to every COVID-19 Vaccine recipient, the adult caregiver accompanying the recipient, or other legal representative. Each COVID-19 Vaccine shipment will include COVID-19 vaccination record cards.
12.	a) Organization must comply with all applicable requirements as set forth by the U.S. Food and Drug Administration, including but not limited to requirements in any EUA that covers COVID-19 Vaccine. b) Organization must administer COVID-19 Vaccine in compliance with all applicable state and territorial vaccination laws.

By signing this form, I certify that all relevant officers, directors, employees, and agents of Organization involved in handling COVID-19 Vaccine understand and will comply with the agreement requirements listed above and that the information provided in sections A and B is true.

The above requirements are material conditions of payment for COVID-19 Vaccine-administration claims submitted by Organization to any federal healthcare benefit program, including but not limited to Medicare and Medicaid, or submitted to any HHS-sponsored COVID-19 relief program, including the Health Resources & Services Administration COVID-19 Uninsured Program. Reimbursement for administering COVID-19 Vaccine is not available under any federal healthcare program if Organization fails to comply with these requirements with respect to the administered COVID-19 Vaccine dose. Each time Organization submits a reimbursement claim for COVID-19 Vaccine administration to any federal healthcare program, Organization expressly certifies that it has complied with these requirements with respect to that administered dose.

Non-compliance with the terms of Agreement may result in suspension or termination from the CDC COVID-19 Vaccination Program and criminal and civil penalties under federal law, including but not limited to the False Claims Act, 31 U.S.C. § 3729 *et seq.*, and other related federal laws, 18 U.S.C. §§ 1001, 1035, 1347, 1349.

By entering Agreement, Organization does not become a government contractor under the Federal Acquisition Regulation.

Coverage under the Public Readiness and Emergency Preparedness (PREP) Act extends to Organization if it complies with the PREP Act and the PREP Act Declaration of the Secretary of Health and Human Services.⁷

³ The disposal process for remaining unused COVID-19 Vaccine and adjuvant may be different from the process for other vaccines; unused vaccines must remain under storage and handling conditions noted in Item 7 until CDC provides disposal instructions; website URL will be made available.

⁶ <https://vaers.hhs.gov/reportevent.html>

⁷ See Pub. L. No. 109-148, Public Health Service Act §§ 319F-3 and 319F-4, 42 U.S.C. § 247d-6d and 42 U.S.C. § 247d-6e; 85 Fed. Reg. 15,198, 15,202 (March 17, 2020).

Figure 53: CDC COVID-19 Vaccination Program Provider Agreement – Page 3



CDC COVID-19 Vaccination Program Provider Agreement

Chief Medical Officer (or Equivalent)

Last name	First name	Middle initial
Signature:		Date:

Chief Executive Officer (or Chief Fiduciary)

Last name	First name	Middle initial
Signature:		Date:

For official use only:

VTrckS ID for this Organization, if applicable: _____

Vaccines for Children (VFC) PIN, if applicable: _____ Other PIN (e.g., state, 317): _____

IIS ID, if applicable: _____

Unique COVID-19 Organization ID (Section A)*: _____

**The jurisdiction's immunization program is required to create a unique COVID-19 ID for the organization named in Section A that includes the awardee jurisdiction abbreviation (e.g., an organization located in Georgia could be assigned "GA123456A"). This ID is needed for CDC to match Organizations (Section A) with one or more Locations (Section B). These unique identifiers are required even if there is only one location associated with an organization.*

Figure 54: CDC COVID-19 Vaccination Program Provider Agreement – Page 4



Section B. CDC COVID-19 Vaccination Program Provider Profile Information

Please complete and sign this form for your Organization location. If you are enrolling on behalf of one or more other affiliated Organization vaccination locations, complete and sign this form for each location. Each individual Organization vaccination location must adhere to the requirements listed in Section A.

ORGANIZATION IDENTIFICATION FOR INDIVIDUAL LOCATIONS				
Organization location name:		Will another Organization location order COVID-19 vaccine for this site?		
		<input type="checkbox"/> Yes; provide Organization name: _____ <input type="checkbox"/> No		
CONTACT INFORMATION FOR LOCATION'S PRIMARY COVID-19 VACCINE COORDINATOR				
Last name:		First name:	Middle initial:	
Telephone:		Email:		
CONTACT INFORMATION FOR LOCATION'S BACK-UP COVID-19 VACCINE COORDINATOR				
Last name:		First name:	Middle initial:	
Telephone:		Email:		
ORGANIZATION LOCATION ADDRESS FOR RECEIPT OF COVID-19 VACCINE SHIPMENTS				
Street address 1:		Street address 2:		
City:	County:	State:	ZIP:	
Telephone:		Fax:		
ORGANIZATION ADDRESS OF LOCATION WHERE COVID-19 VACCINE WILL BE ADMINISTERED (IF DIFFERENT FROM RECEIVING LOCATION)				
Street address 1:		Street address 2:		
City:	County:	State:	ZIP:	
Telephone:		Fax:		
DAYS AND TIMES VACCINE COORDINATORS ARE AVAILABLE FOR RECEIPT OF COVID-19 VACCINE SHIPMENTS				
Monday	Tuesday	Wednesday	Thursday	Friday
AM:	AM:	AM:	AM:	AM:
PM:	PM:	PM:	PM:	PM:
<i>For official use only:</i>				
VTrackS ID for this location, if applicable: _____		Vaccines for Children (VFC) PIN, if applicable: _____		
IIS ID, if applicable: _____	Unique COVID-19 Organization ID (from Section A): _____	Unique Location ID**: _____		
<p>**The jurisdiction's immunization program is required to create an additional unique Location ID for each location completing Section B. The number will include the awardee jurisdiction abbreviation. For example, if an organization (Section A) in Georgia (e.g., GA123456A), has three locations (main location plus two additional) completing section B, they could be numbered as GA123456B1, GA123456B2, and GA123456B3.</p>				

Figure 55: CDC COVID-19 Vaccination Program Provider Agreement – Page 5



CDC COVID-19 Vaccination Program Provider Profile Information	
COVID-19 VACCINATION PROVIDER TYPE FOR THIS LOCATION (SELECT ONE)	
<ul style="list-style-type: none"> <input type="checkbox"/> Commercial vaccination service provider <input type="checkbox"/> Corrections/detention health services <input type="checkbox"/> Health center – community (non-Federally Qualified Health Center/non-Rural Health Clinic) <input type="checkbox"/> Health center – migrant or refugee <input type="checkbox"/> Health center – occupational <input type="checkbox"/> Health center – STD/HIV clinic <input type="checkbox"/> Health center – student <input type="checkbox"/> Home health care provider <input type="checkbox"/> Hospital <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Tribal health <input type="checkbox"/> Medical practice – family medicine <input type="checkbox"/> Medical practice – pediatrics <input type="checkbox"/> Medical practice – internal medicine <input type="checkbox"/> Medical practice – OB/GYN <input type="checkbox"/> Medical practice – other specialty 	<ul style="list-style-type: none"> <input type="checkbox"/> Pharmacy – chain <input type="checkbox"/> Pharmacy – independent <input type="checkbox"/> Public health provider – public health clinic <input type="checkbox"/> Public health provider – Federally Qualified Health Center <input type="checkbox"/> Public health provider – Rural Health Clinic <input type="checkbox"/> Long-term care – nursing home, skilled nursing facility, federally certified <input type="checkbox"/> Long-term care – nursing home, skilled nursing facility, non-federally certified <input type="checkbox"/> Long-term care – assisted living <input type="checkbox"/> Long-term care – intellectual or developmental disability <input type="checkbox"/> Long-term care – combination (e.g., assisted living and nursing home in same facility) <input type="checkbox"/> Urgent care <input type="checkbox"/> Other (Specify: _____)
SETTING(S) WHERE THIS LOCATION WILL ADMINISTER COVID-19 VACCINE (SELECT ALL THAT APPLY)	
<ul style="list-style-type: none"> <input type="checkbox"/> Childcare or daycare facility <input type="checkbox"/> College, technical school, or university <input type="checkbox"/> Community center <input type="checkbox"/> Correctional/detention facility <input type="checkbox"/> Health care provider office, health center, medical practice, or outpatient clinic <input type="checkbox"/> Hospital (i.e., inpatient facility) <input type="checkbox"/> In-home <input type="checkbox"/> Long-term care facility (e.g., nursing home, assisted living, independent living, skilled nursing) 	<ul style="list-style-type: none"> <input type="checkbox"/> Pharmacy <input type="checkbox"/> Public health clinic (e.g., local health department) <input type="checkbox"/> School (K – grade 12) <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary or off-site vaccination clinic – point of dispensing (POD) <input type="checkbox"/> Temporary location – mobile clinic <input type="checkbox"/> Urgent care facility <input type="checkbox"/> Workplace <input type="checkbox"/> Other (Specify: _____)
APPROXIMATE NUMBER OF PATIENTS/CLIENTS ROUTINELY SERVED BY THIS LOCATION	
Number of children 18 years of age and younger: _____ (Enter "0" if the location does not serve this age group.) <input type="checkbox"/> Unknown	
Number of adults 19 – 64 years of age: _____ (Enter "0" if the location does not serve this age group.) <input type="checkbox"/> Unknown	
Number of adults 65 years of age and older: _____ (Enter "0" if the location does not serve this age group.) <input type="checkbox"/> Unknown	
Number of unique patients/clients seen per week, on average: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable (e.g., for commercial vaccination service providers)	
INFLUENZA VACCINATION CAPACITY FOR THIS LOCATION	
Number of influenza vaccine doses administered during the peak week of the 2019–20 influenza season: _____ (Enter "0" if no influenza vaccine doses were administered by this location in 2019-20) <input type="checkbox"/> Unknown	
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Figure 56: CDC COVID-19 Vaccination Program Provider Agreement – Page 6



CDC COVID-19 Vaccination Program Provider Profile Information

POPULATION(S) SERVED BY THIS LOCATION (SELECT ALL THAT APPLY)

- General pediatric population
- General adult population
- Adults 65 years of age and older
- Long term care facility residents (nursing home, assisted living, or independent living facility)
- Health care workers
- Critical infrastructure/essential workers (e.g., education, law enforcement, food/agricultural workers, fire services)
- Military – active duty/reserves
- Military – veteran
- People experiencing homelessness
- Pregnant women
- Racial and ethnic minority groups
- Tribal communities
- People who are incarcerated/detained
- People living in rural communities
- People who are under-insured or uninsured
- People with disabilities
- People with underlying medical conditions* that are risk factors for severe COVID-19 illness
- Other people at higher-risk for COVID-19 (Specify: _____)

DOES YOUR ORGANIZATION CURRENTLY REPORT VACCINE ADMINISTRATION DATA TO THE STATE, LOCAL, OR TERRITORIAL IMMUNIZATION INFORMATION SYSTEM (IIS)?

- Yes [List IIS Identifier: _____]
- No
- Not applicable

If "No," please explain planned method for reporting vaccine administration data to the jurisdiction's IIS or other designated system as required:

If "Not applicable," please explain:

ESTIMATED NUMBER OF 10-DOSE MULTIDOSE VIALS (MDVs) YOUR LOCATION IS ABLE TO STORE DURING PEAK VACCINATION PERIODS (E.G., DURING BACK-TO-SCHOOL OR INFLUENZA VACCINE SEASON) AT THE FOLLOWING TEMPERATURES:

Refrigerated (2°C to 8°C):	<input type="checkbox"/> No capacity	<input type="checkbox"/> Approximately _____ additional 10-dose MDVs
Frozen (-15° to -25°C):	<input type="checkbox"/> No capacity	<input type="checkbox"/> Approximately _____ additional 10-dose MDVs
Ultra-frozen (-60° to -80°C):	<input type="checkbox"/> No capacity	<input type="checkbox"/> Approximately _____ additional 10-dose MDVs

STORAGE UNIT DETAILS FOR THIS LOCATION

List brand/model/type of storage units to be used for storing COVID-19 vaccine at this location:

1. Example: CDC & Co/Red series two-door/refrigerator
- 2.
- 3.
- 4.
- 5.

I attest that each unit listed will maintain the appropriate temperature range indicated above: (please sign and date)

Medical/pharmacy director or location's vaccine coordinator signature

Date

* <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-increased-risk.html>

Figure: 57: CDC COVID-19 Vaccination Program Provider Agreement – Page 7



Appendix C. Frequently Asked Questions

- How do I know if I previously registered in ImmTrac2, TVFC, or ASN?
You can see if you're already registered in ImmTrac2 or TVFC/ASN and if so, see your ImmTrac2 org code or your TVFC/ASN PIN by clicking the [OrgCode/PIN Lookup Tool](#).
- How do I look up my ImmTrac2 Org Code or TVFC/ASN PIN?
See above answer.
- How do I search for my provider's NPI number?
By going to <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, you can look up your NPI number.
- I registered my organization for ImmTrac2 and to pre-book the COVID-19 vaccine, but I didn't see a place to review, remove, and/or add more users. How do I do that?
Use the template shown in [Appendix D: ImmTrac2 Add/Remove User Template](#).



Appendix D. ImmTrac2 Add/Remove User Template

Instructions:

All ImmTrac2 new user requests must be requested by the listed Point of Contact (POC) at the registered organization. Requests should be e-mailed to ImmTrac2@dshs.texas.gov using the format provided below.

Security Note:

ImmTrac2 login credentials are assigned to an individual person and must not be shared. Each ImmTrac2 user account requires a unique e-mail address in order for the ImmTrac2 user to reset their own passwords when needed. Organization POC's should carefully consider which persons need ImmTrac2 access. Please do not add more users than what is needed. The more users that are requested, the longer the user creation process may take. Please instruct users at your organization to login as soon as possible. If new user accounts are not accessed within 30 days of creation, the account will be locked. If new user accounts are never accessed within 120 days of creation, they will be deleted.

ORGANIZATION NAME:

STREET ADDRESS:

POINT OF CONTACT FULL NAME:

PHONE NUMBER:

POC EMAIL ADDRESS:

ORGANIZATION'S ORG CODE, TX IIS ID# (aka PFS ID#) if known:



=====

Please provide the following information for each individual user.

=====

1st User

USER FIRST NAME:

USER LAST NAME:

UNIQUE USER EMAIL ADDRESS:

USER JOB TITLE:

CLINICIAN / NURSES LICENSE #:

PHONE NUMBER:

=====

2nd User

USER FIRST NAME:

USER LAST NAME:

UNIQUE USER EMAIL ADDRESS:

USER JOB TITLE:

CLINICIAN / NURSES LICENSE #:

PHONE NUMBER:



=====

3rd User

USER FIRST NAME:

USER LAST NAME:

UNIQUE USER EMAIL ADDRESS:

USER JOB TITLE:

CLINICIAN / NURSES LICENSE #:

PHONE NUMBER:

=====

Please copy and paste the fields below for each additional user.

=====

USER FIRST NAME:

USER LAST NAME:

UNIQUE USER EMAIL ADDRESS:

USER JOB TITLE:

CLINICIAN / NURSES LICENSE #:

PHONE NUMBER:

=====