TEXAS Health and Human Services | Texas Department of State Health Services

The Texas Immunization Registry:

Texas DSHS Immunization Portal Registration Guide

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Contents

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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.

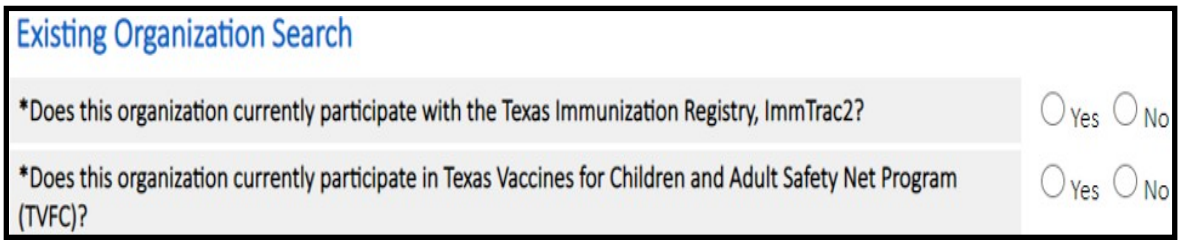


Figure 4: Existing Organization Search

Figure 5: ImmTrac2 Org Code Search

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.

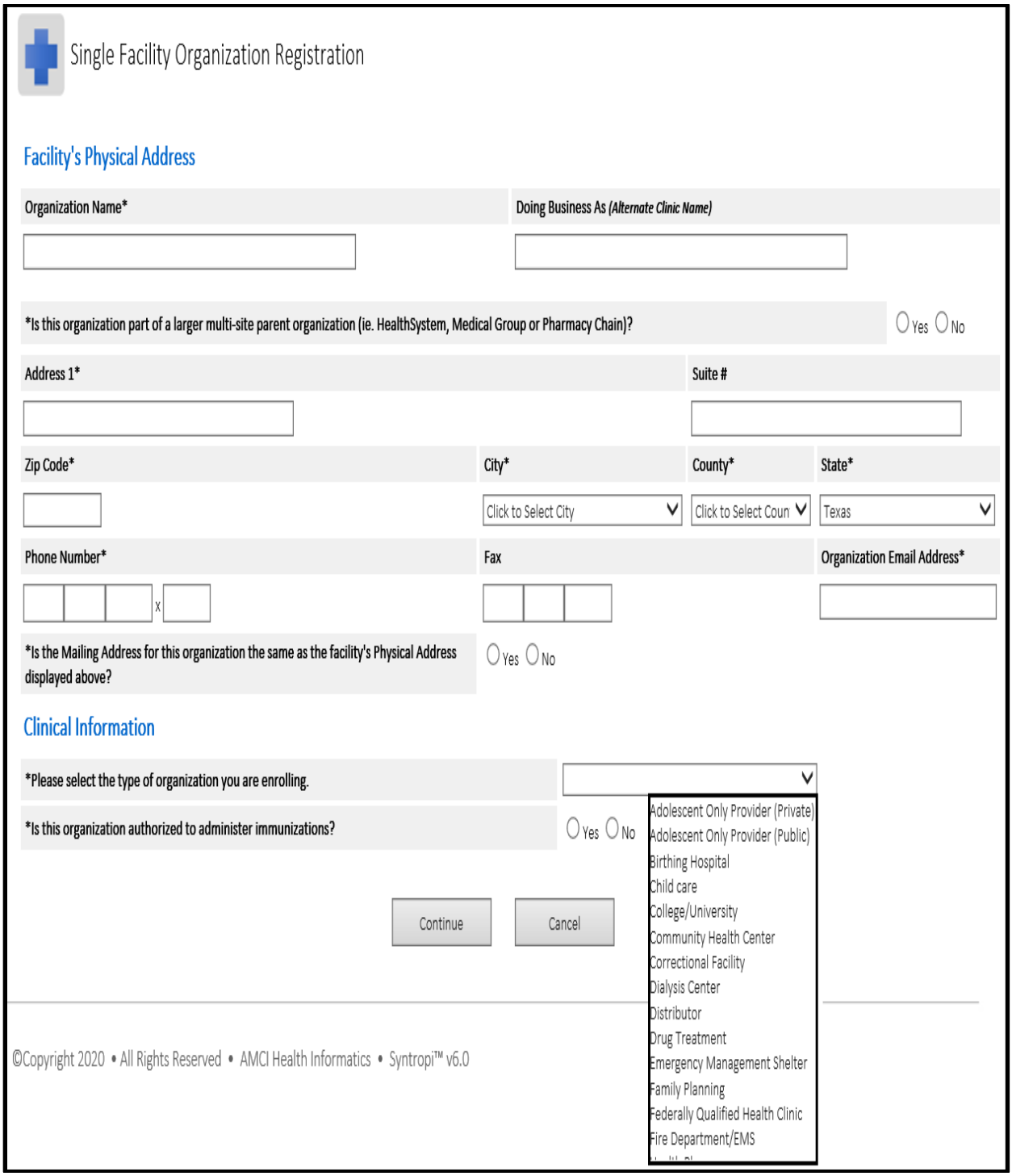


Figure 7: Single Facility Organization Registration

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*.

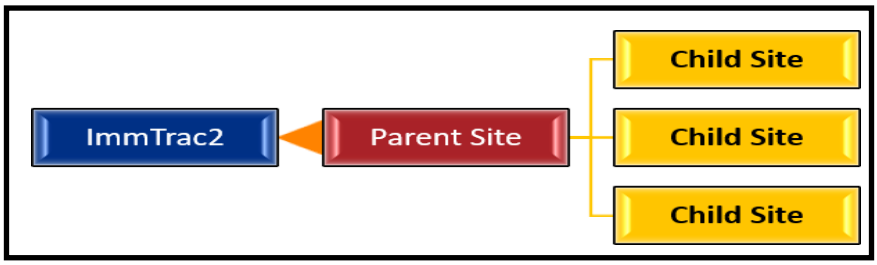


Figure 8: Parent/Child Organization

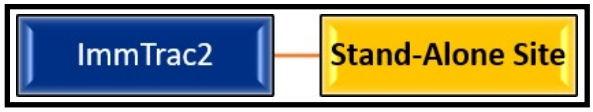


Figure 9: Stand-Alone Site

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*.

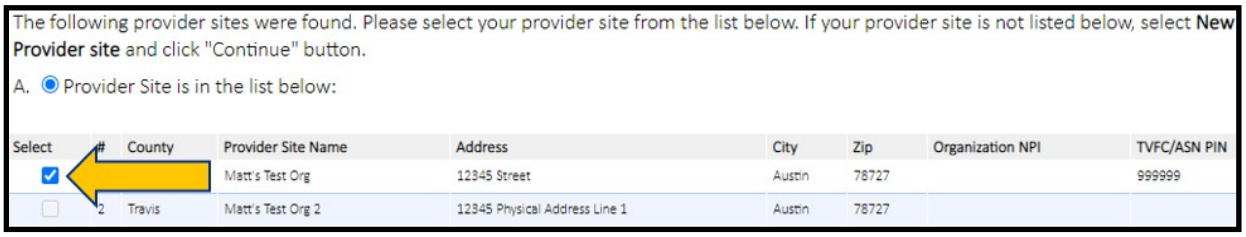


Figure 10: Previous Registration is a Match

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

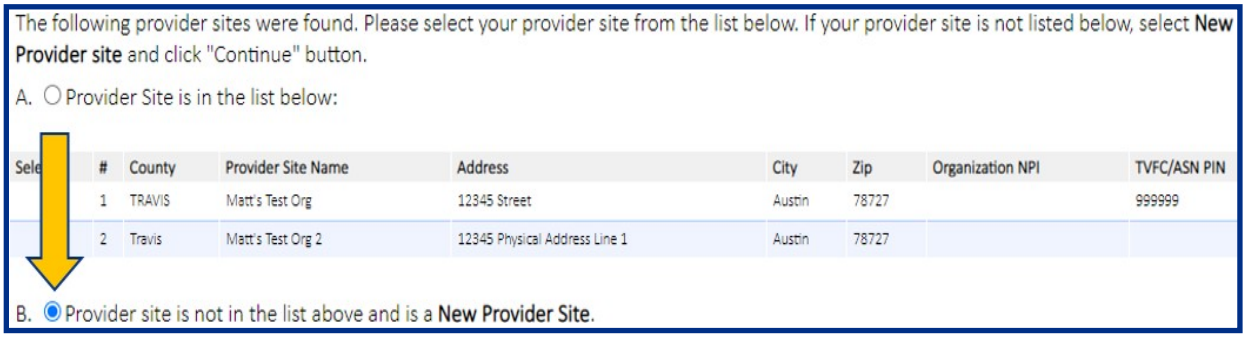


Figure 11: Provider Site Not on List of Registrations

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*.

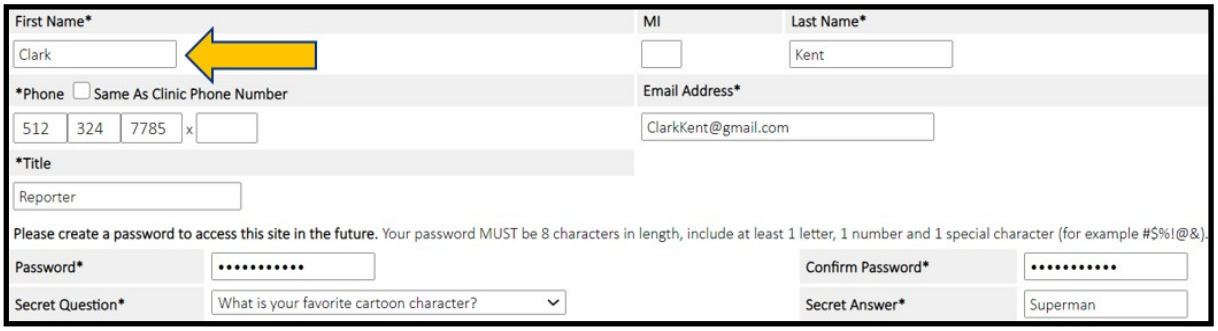


Figure 12: Submit Data About Yourself

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

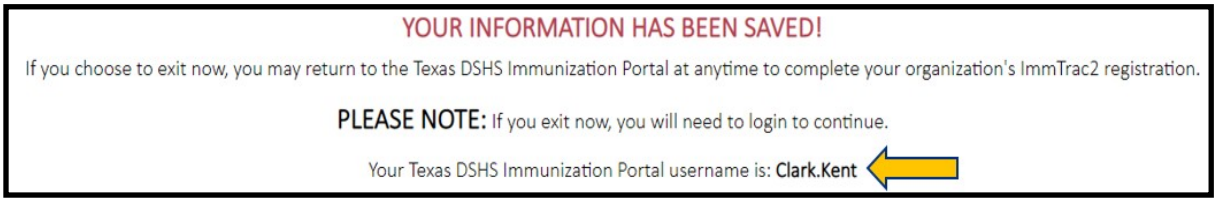


Figure 13: Your Information Has Been Saved

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*.

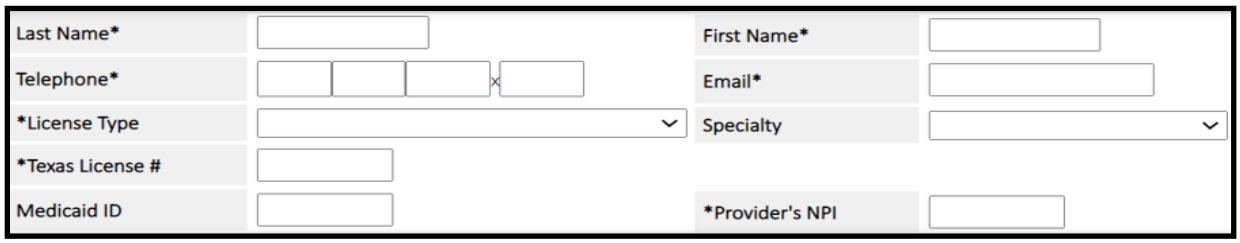


Figure 14: Responsible Medical Provider Information

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*.

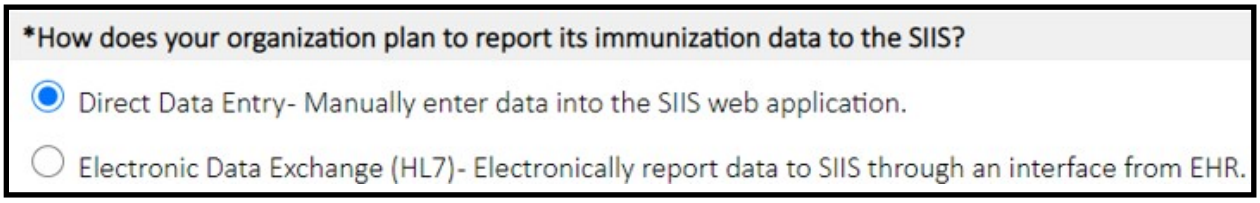


Figure 15: Direct Data Entry Selection

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

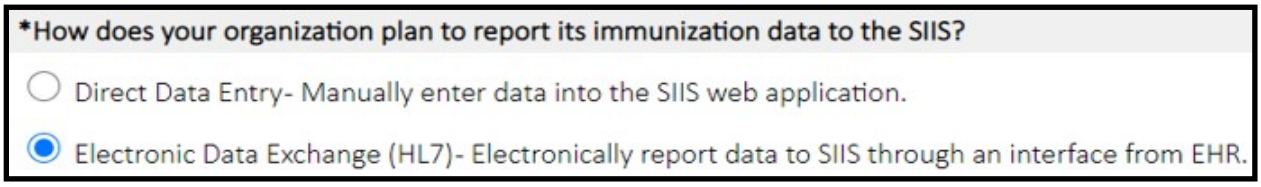


Figure 16: Electronic Data Exchange (HL7) Selection

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".

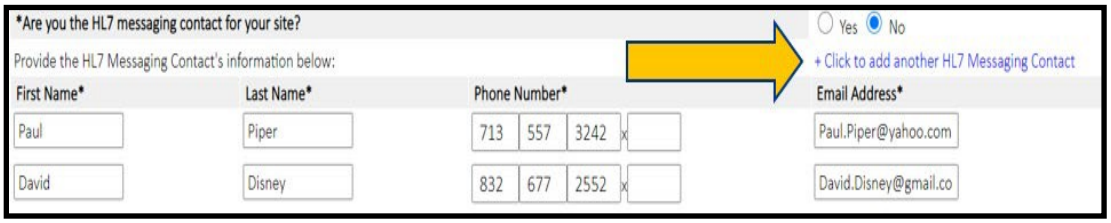


Figure 17: HL7 Messaging Contact

- 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 [+].

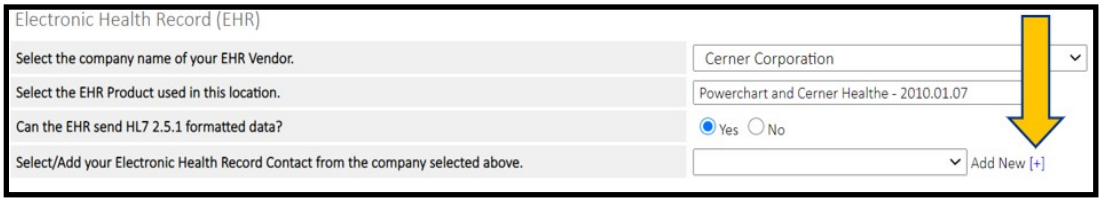


Figure 18: Electronic Health Record (EHR) Information

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

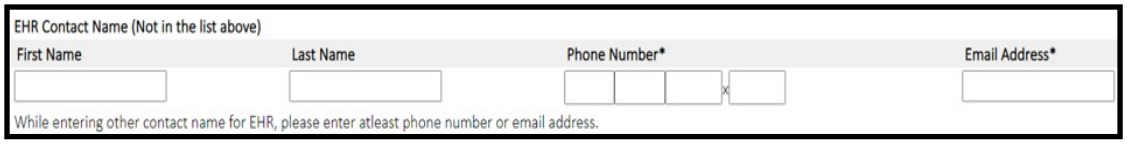


Figure 19: EHR Contact Name

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*.

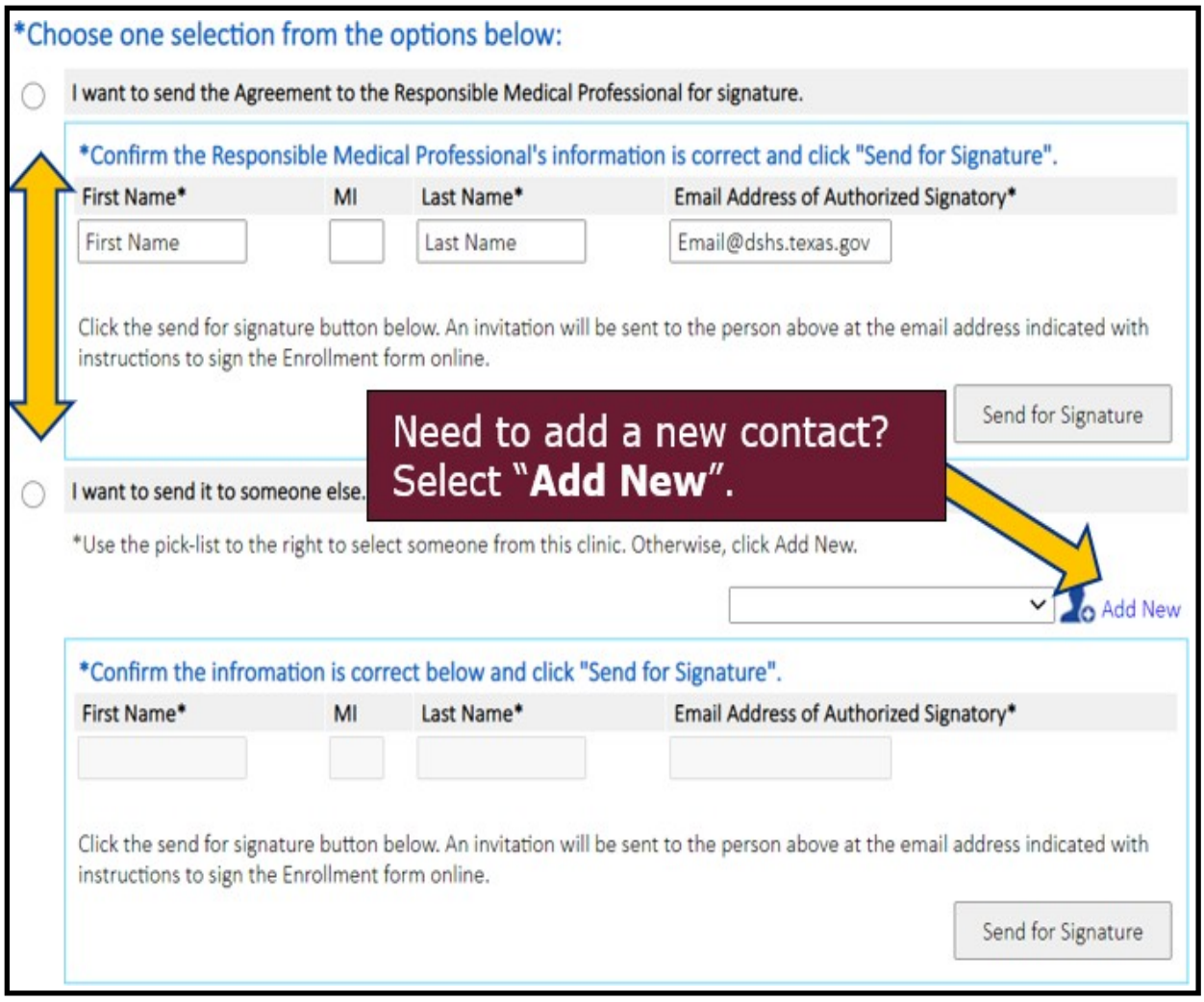
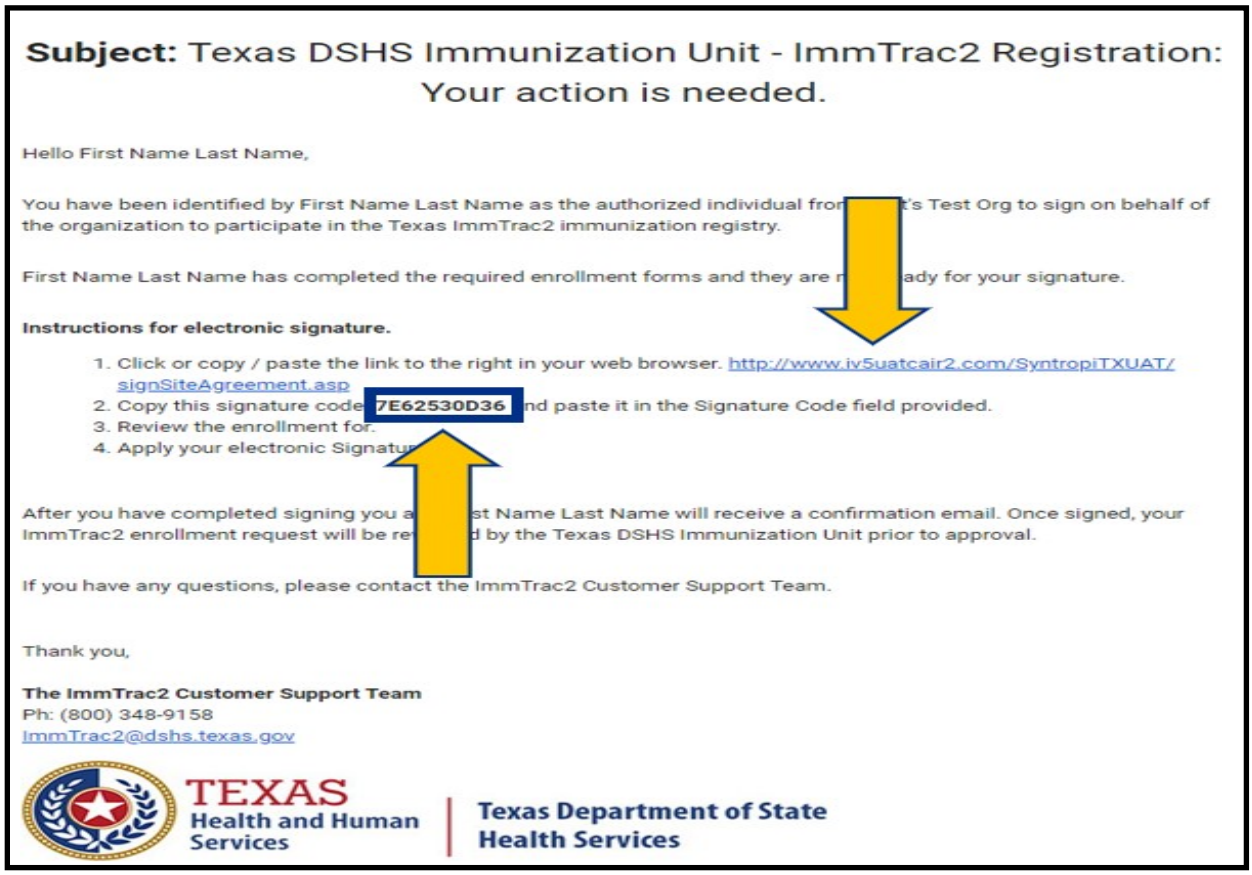


Figure 22: Choose the Contact to Sign and Submit Agreement

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*.



Subject: Texas DSHS Immunization Unit - ImmTrac2 Registration: Your action is needed.

Hello First Name Last Name,

You have been identified by First Name Last Name as the authorized individual fro t's Test Org to sign on behalf of the organization to participate in the Texas ImmTrac2 immunization registry.

First Name Last Name has completed the required enrollment forms and they are r ady 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/signSiteAgreement.asp
2. Copy this signature code 7E62530D36 nd paste it in the Signature Code field provided.
3. Review the enrollment for.
4. Apply your electronic Signatu

After you have completed signing you a st Name Last Name will receive a confirmation email. Once signed, your ImmTrac2 enrollment request will be re d by the Texas DSHS Immunization Unit prior to approval.

If you have any questions, please contact the ImmTrac2 Customer Support Team.

Thank you,

The ImmTrac2 Customer Support Team
Ph: (800) 348-9158
ImmTrac2@dshs.texas.gov

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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*.

IIS Electronic Signature Portal

Instructions for electronic signature.

1. Enter your signature code in the Signature Code field.
2. Review the enrollment for.
3. Apply your electronic Signature.

*Enter the Signature Code from your Request to Signature email.: 7E62530D36 Validate Code

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*.

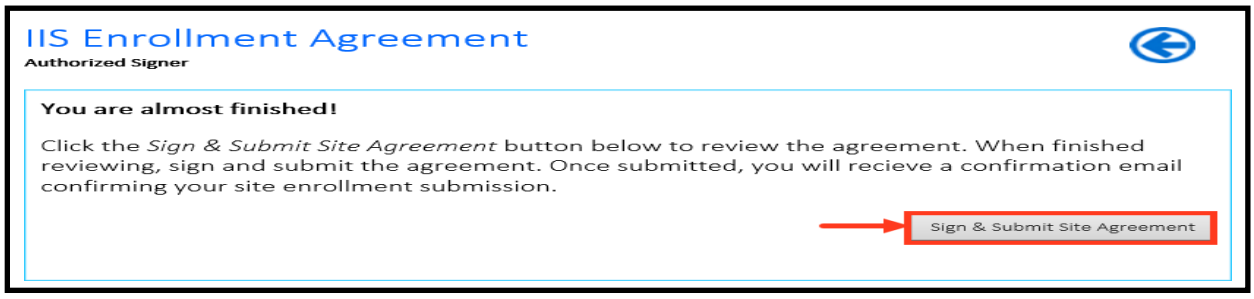

Figure 25: Sign & Submit Site Agreement

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*.

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*.

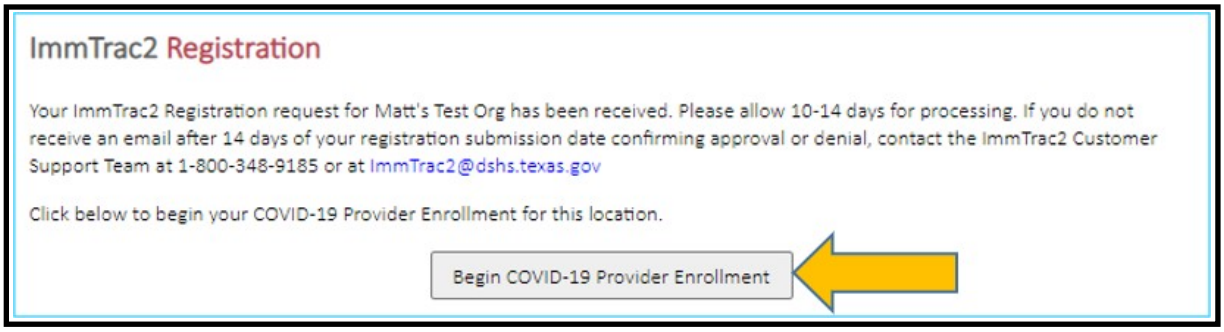

Figure 29: ImmTrac2 Registration Request has been Received

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.

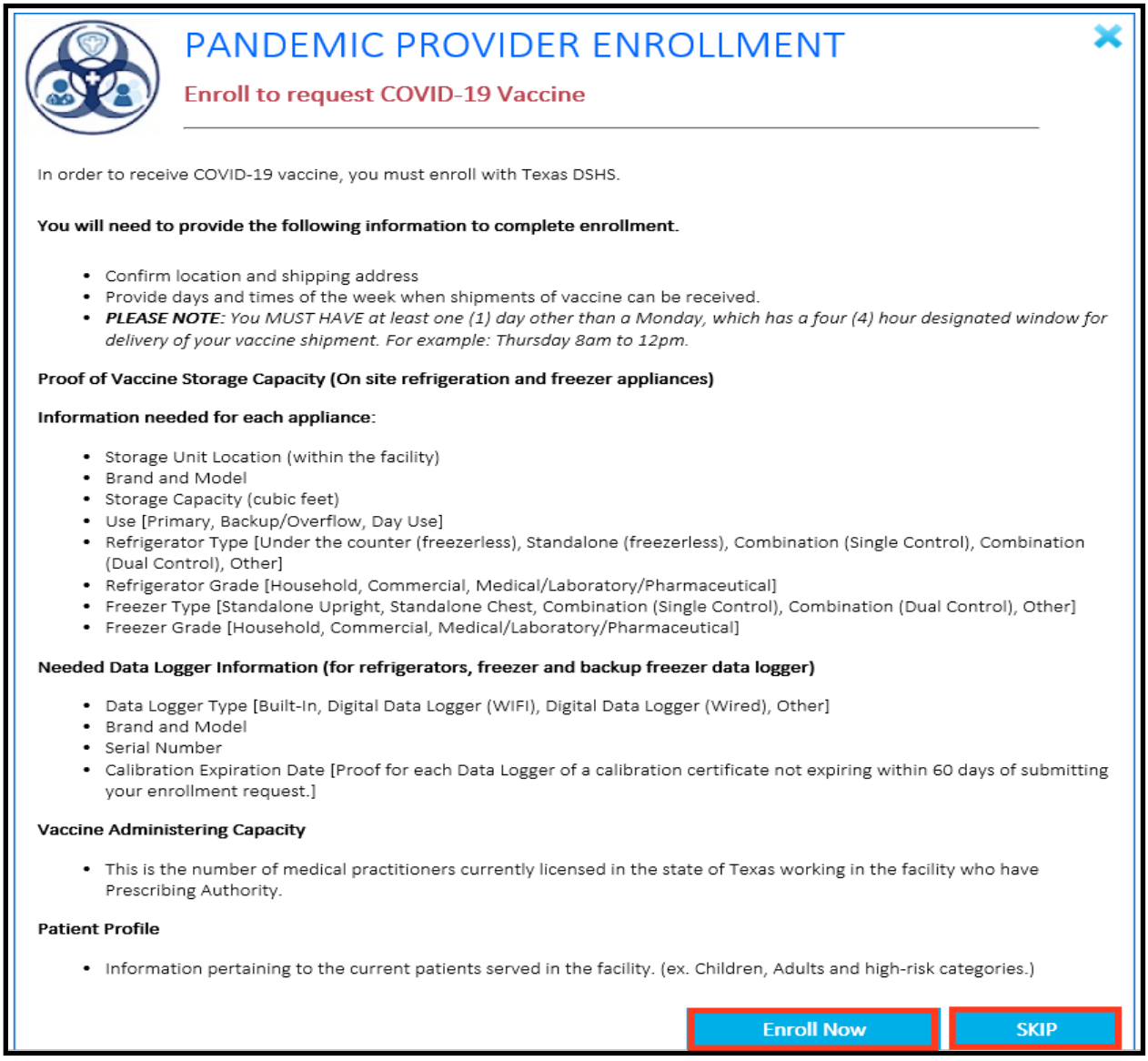

Figure 31: Info Needed for Pandemic Provider Enrollment

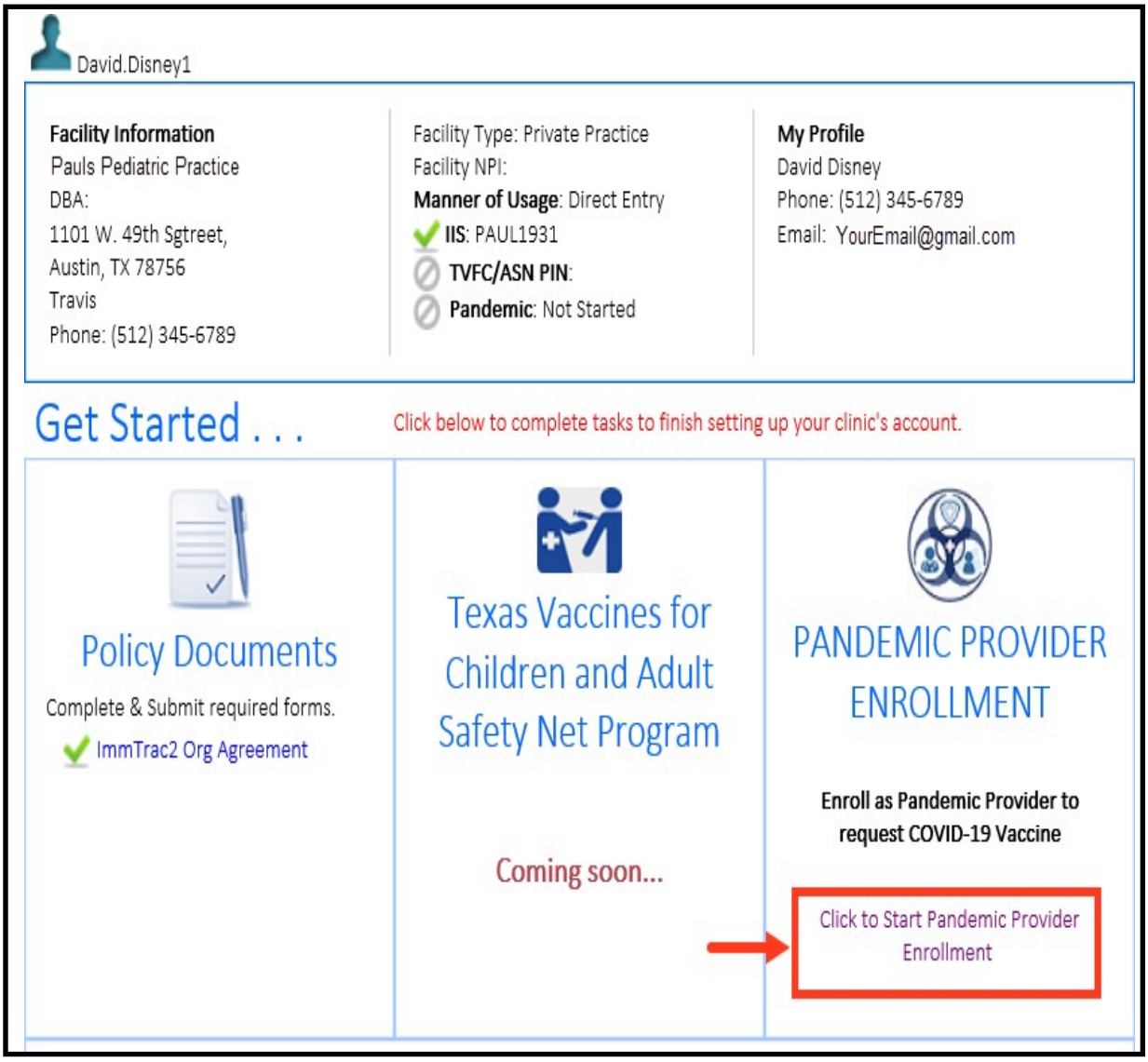

Figure 32: "Get Started" Screen

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.

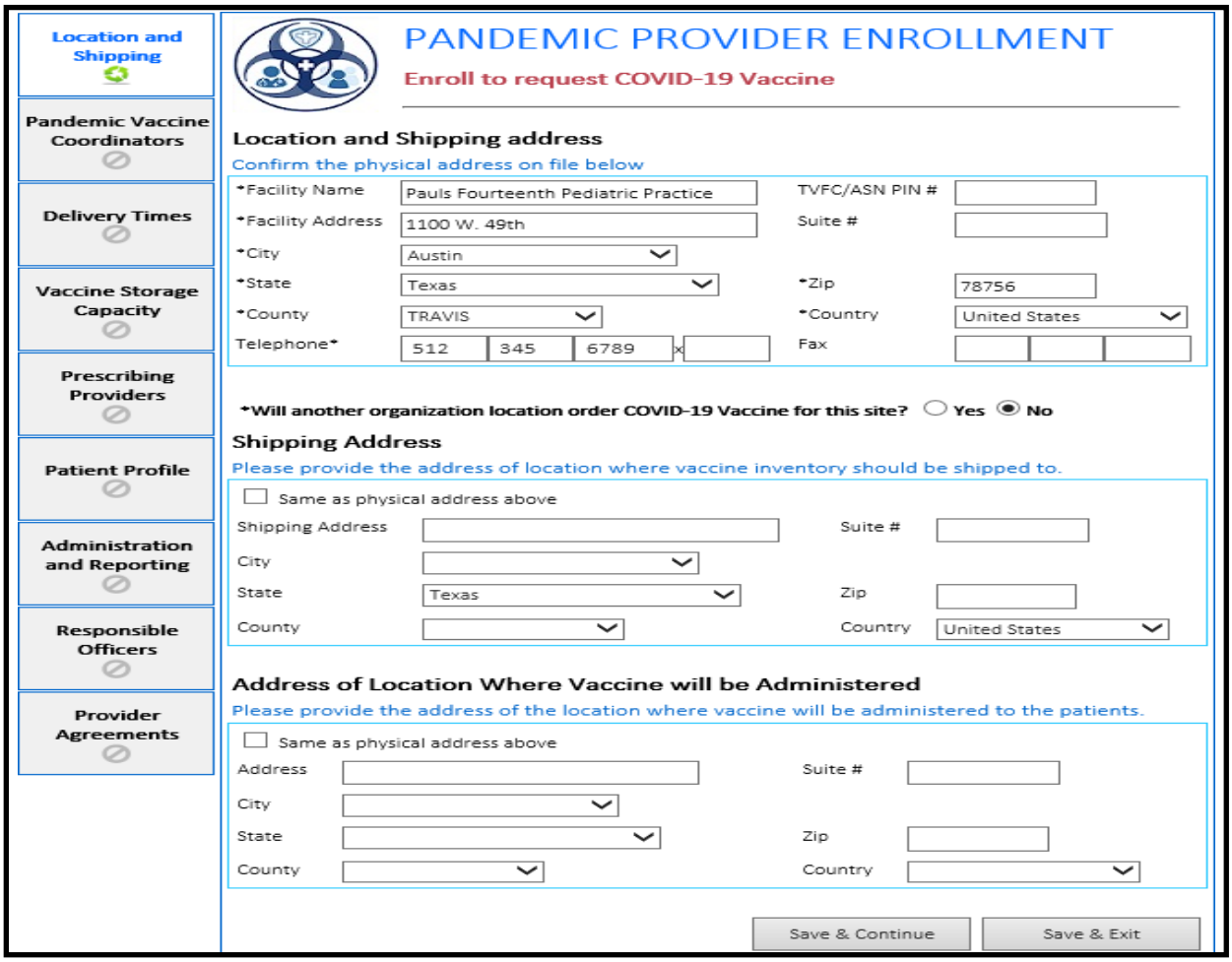

Figure 33: Location and Shipping

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.

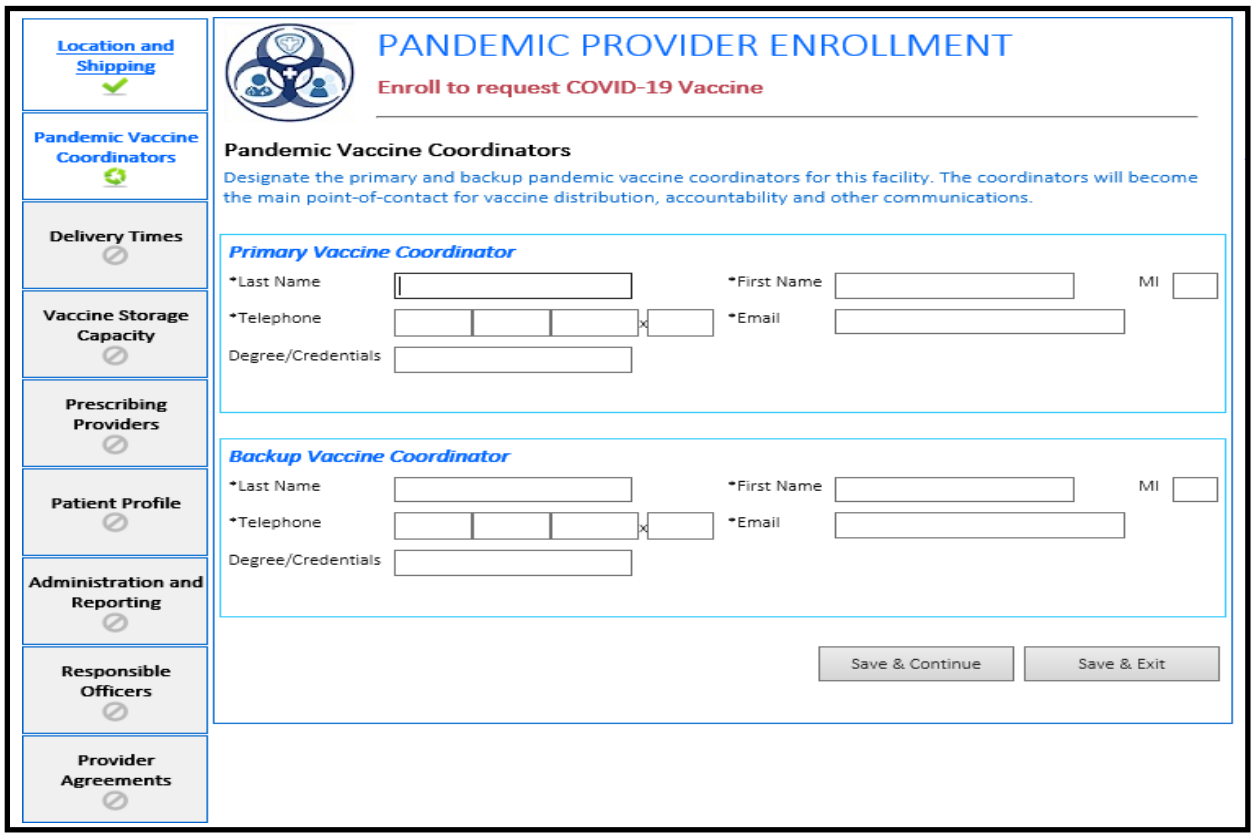

Figure 34: Primary and Backup Vaccine Coordinators

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).*

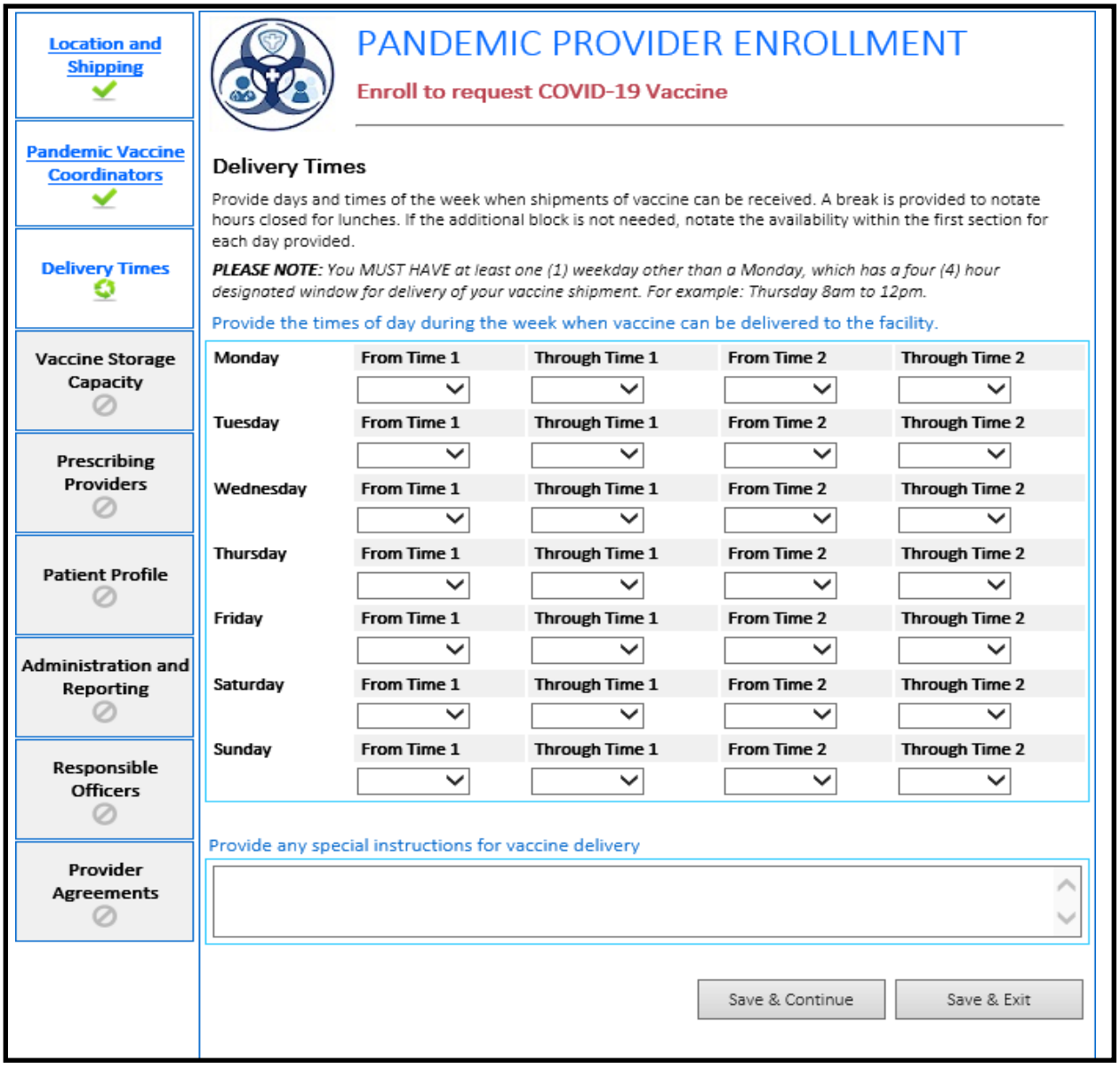

Figure 35: Delivery Times

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.

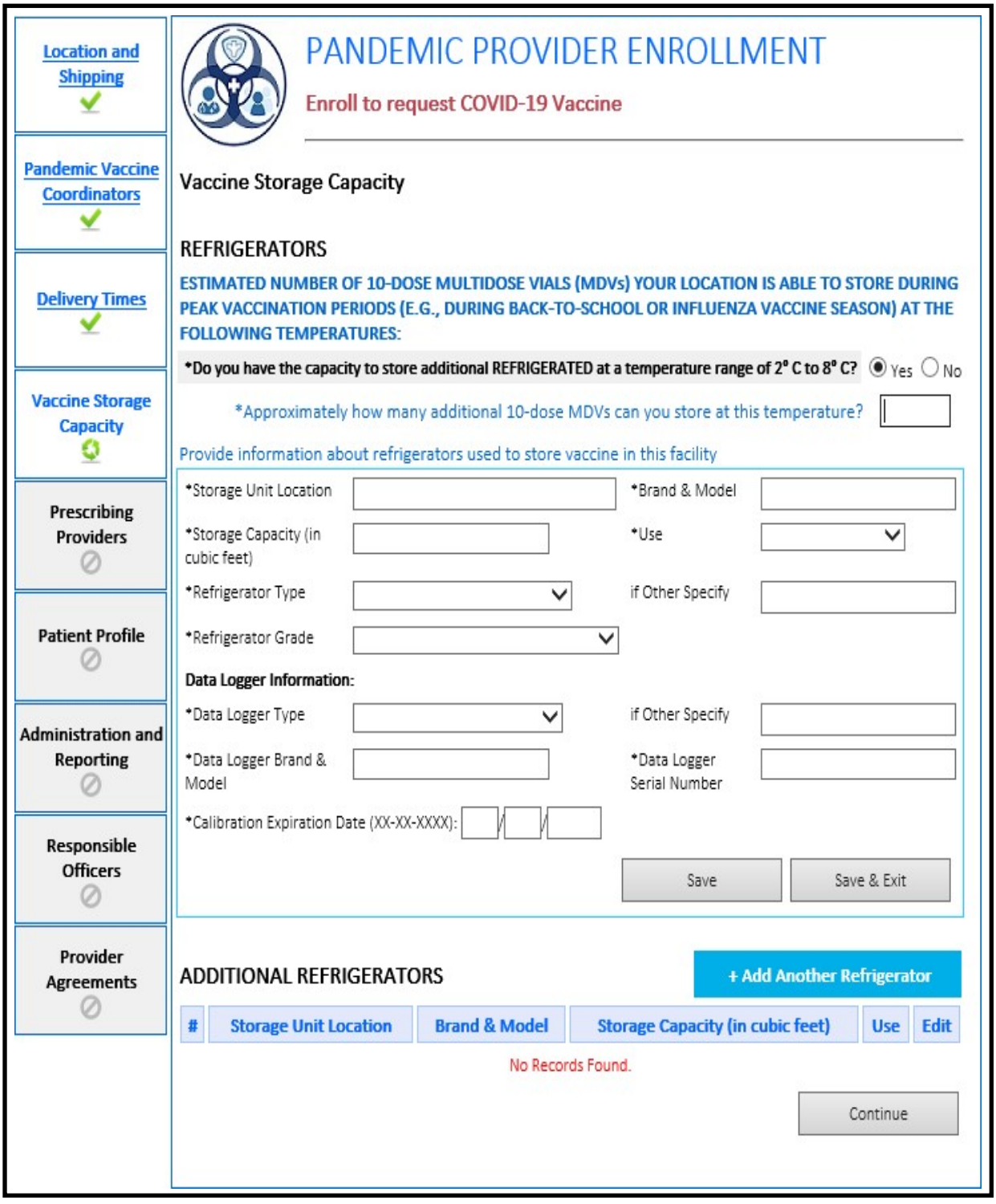

Figure 36: Vaccine Storage Capacity

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.

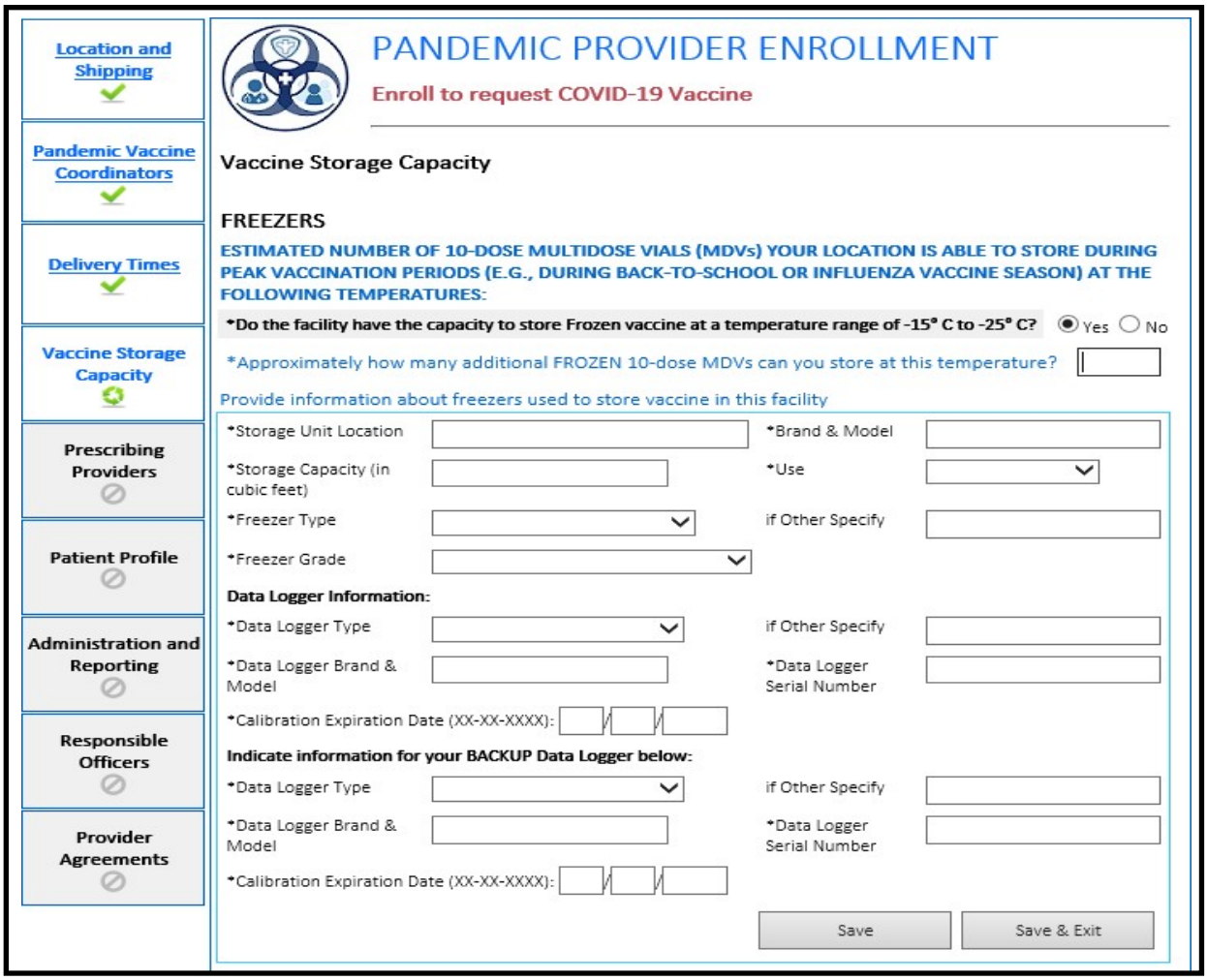

Figure 37: Freezers

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.

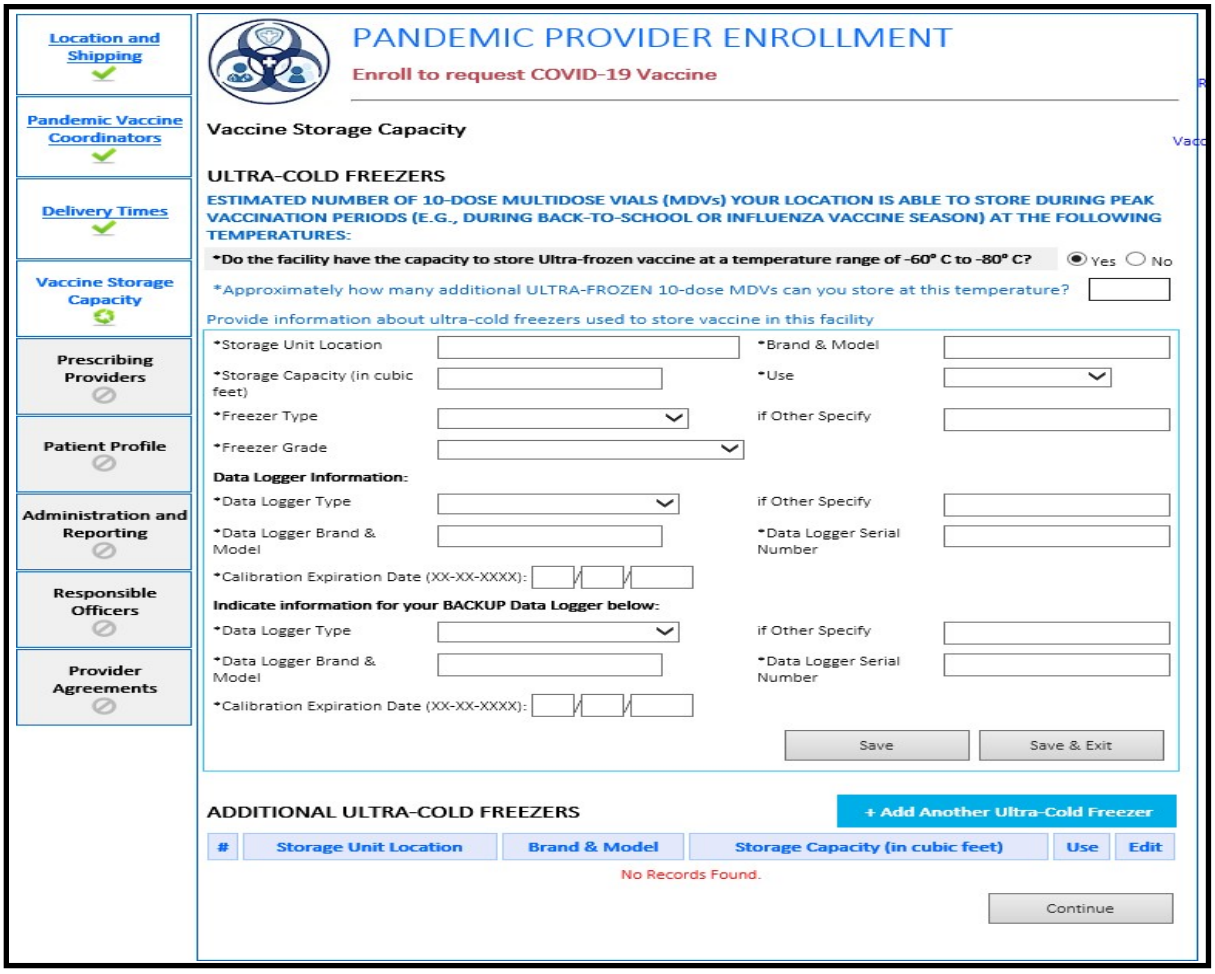

Figure 38: Ultra-Cold Freezers

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**.

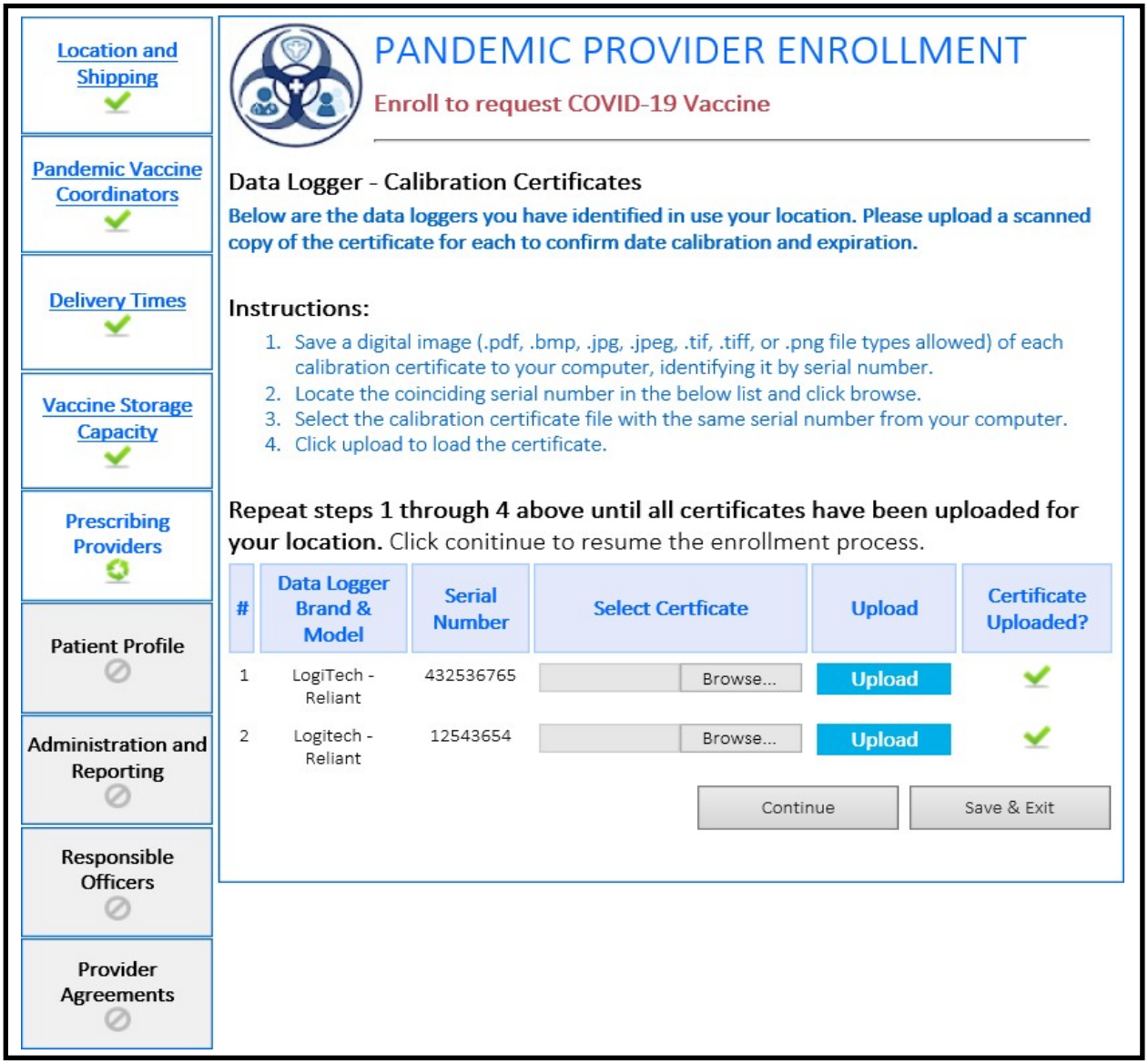

Figure 39: Data Logger Calibration Certificates

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.

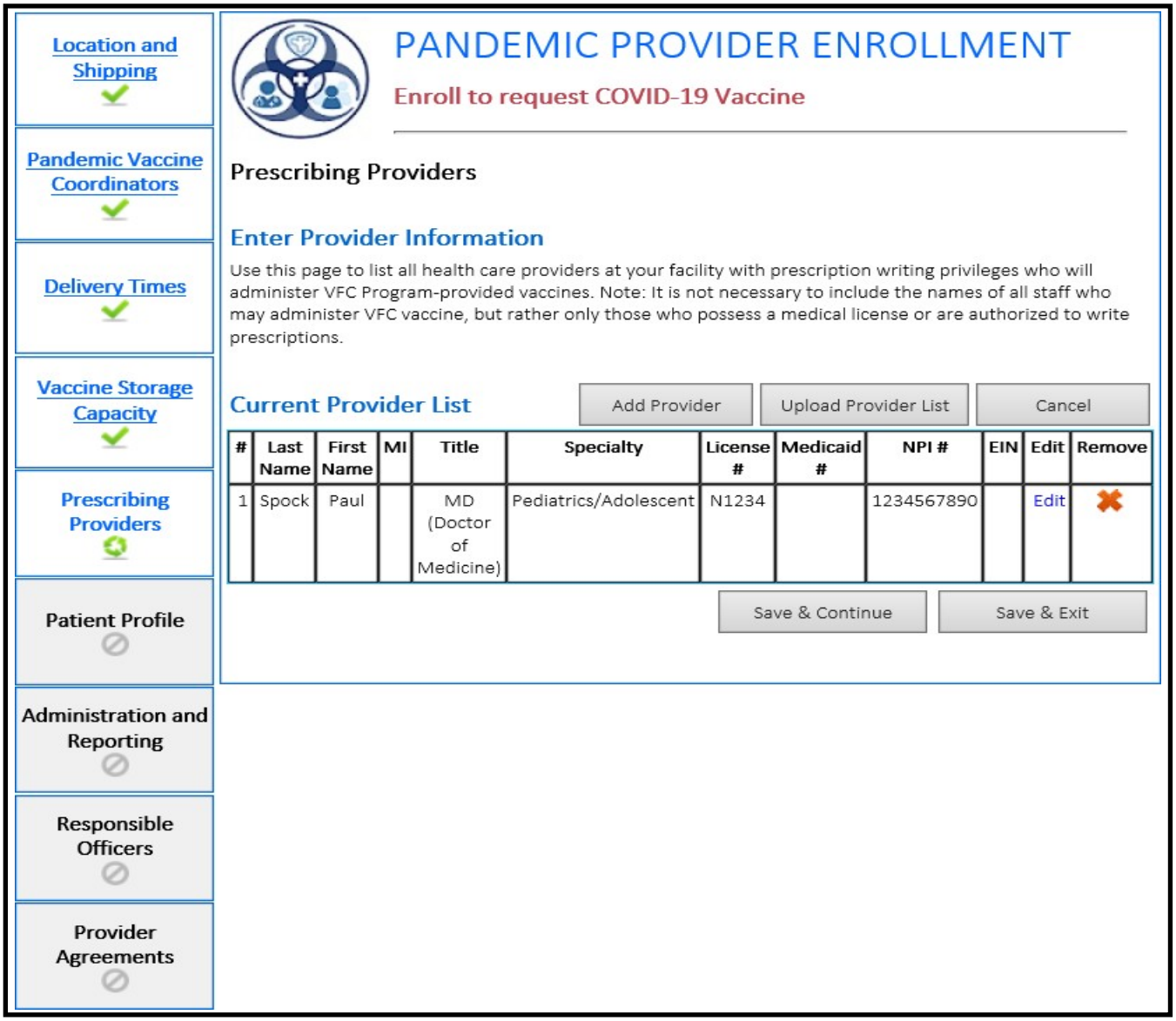

Figure 40: Prescribing Providers - Current Provider List

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.**

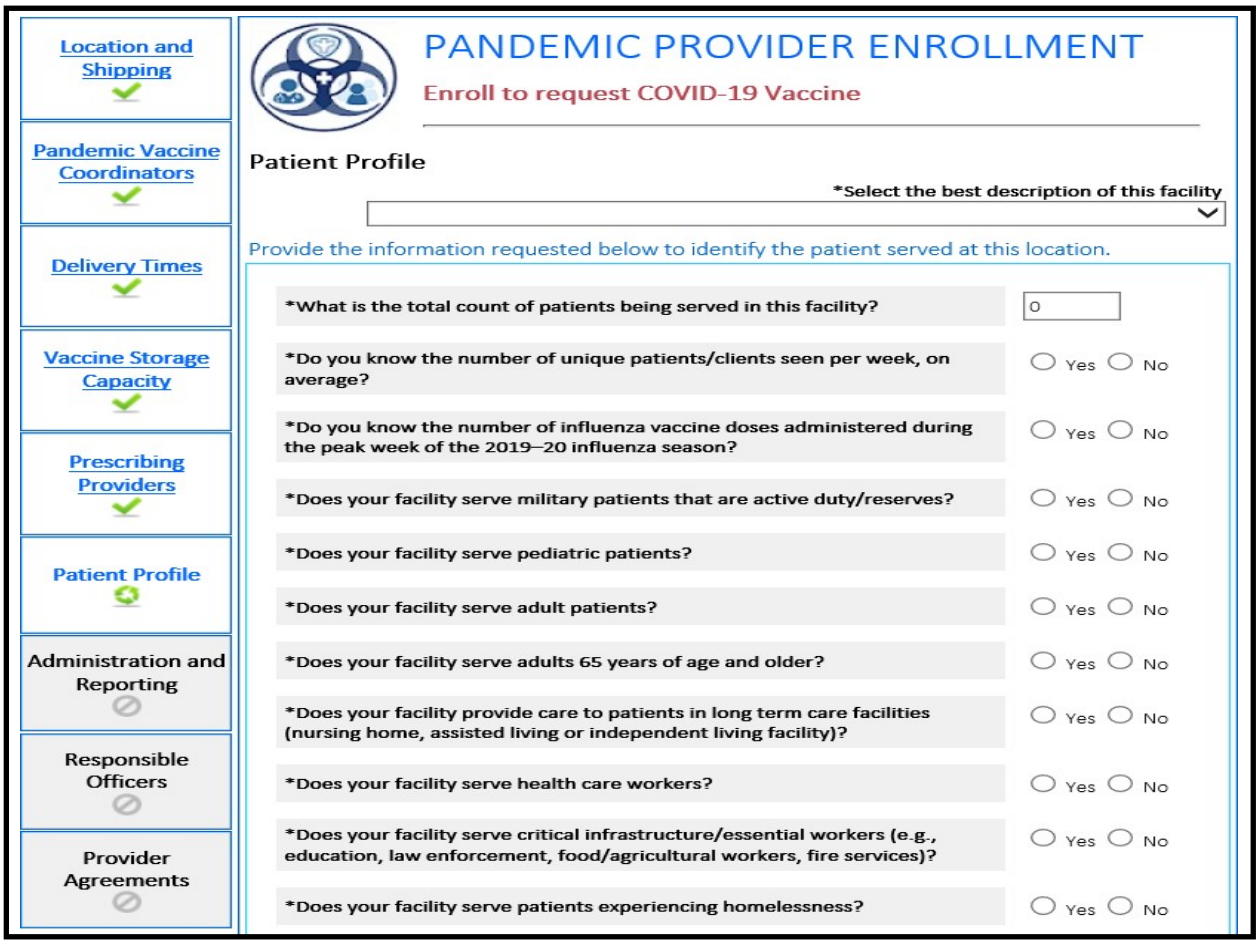

Figure 41: Patient Profile - Top Half

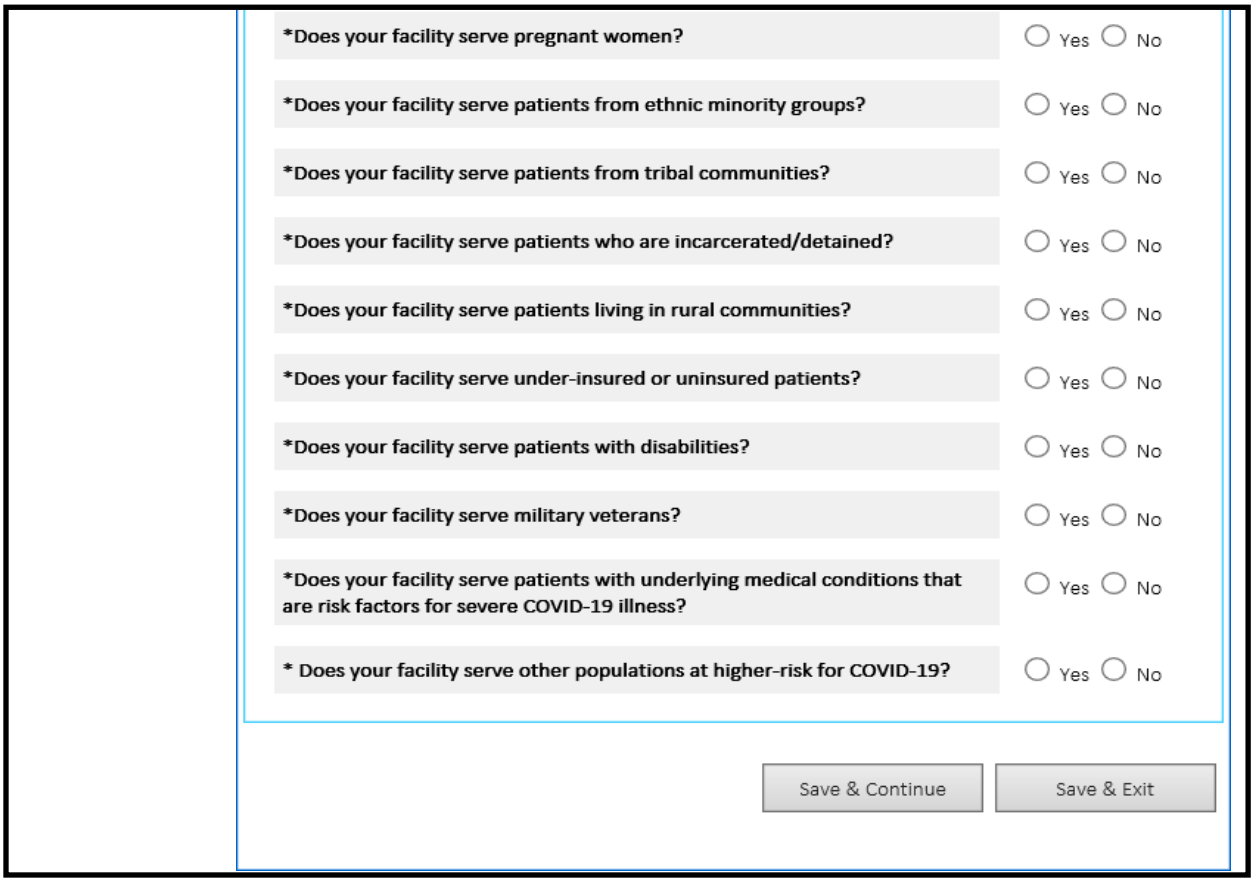

Figure 42: Patient Profile Bottom Half

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.

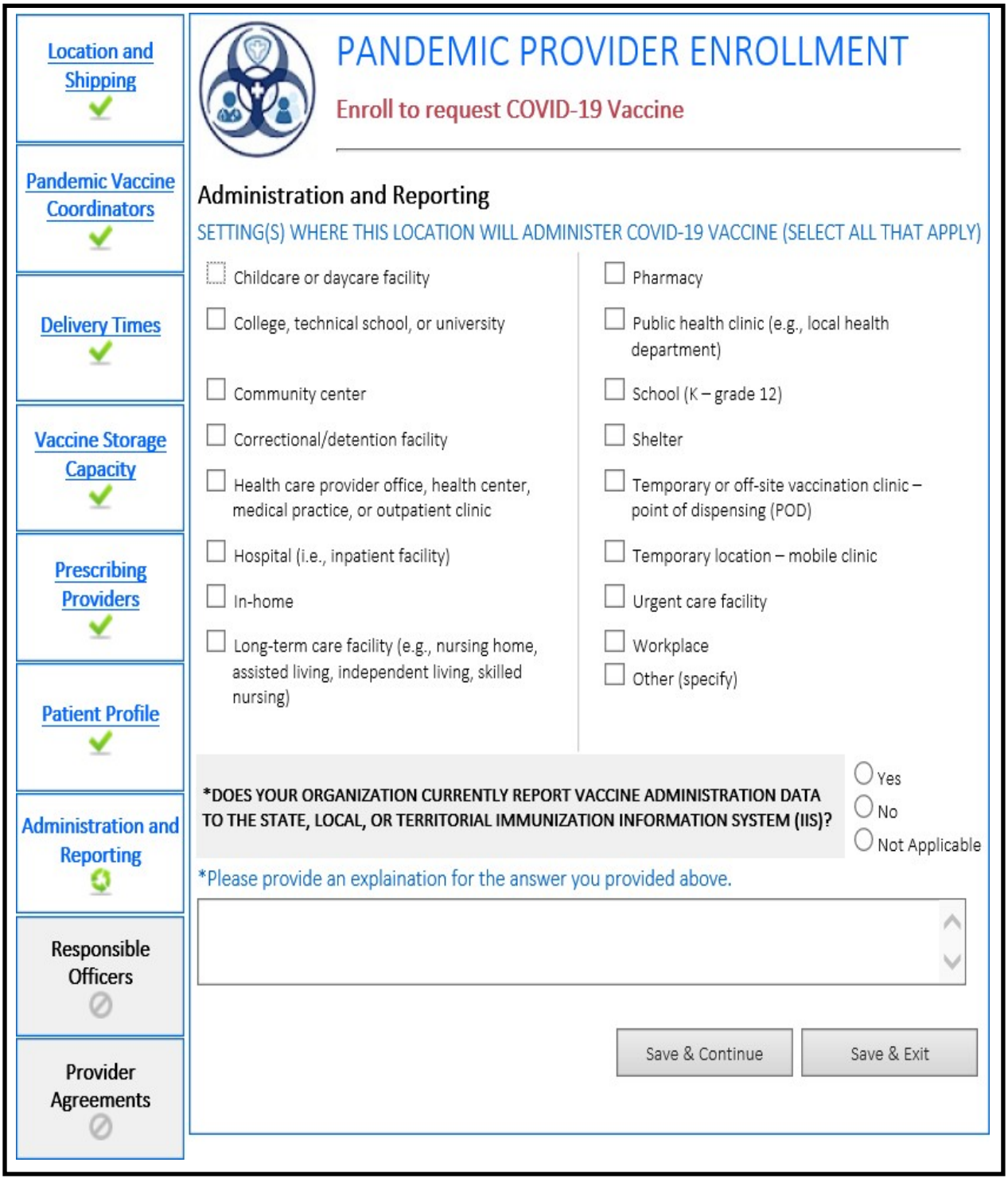

Figure 43: Administration and Reporting

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.

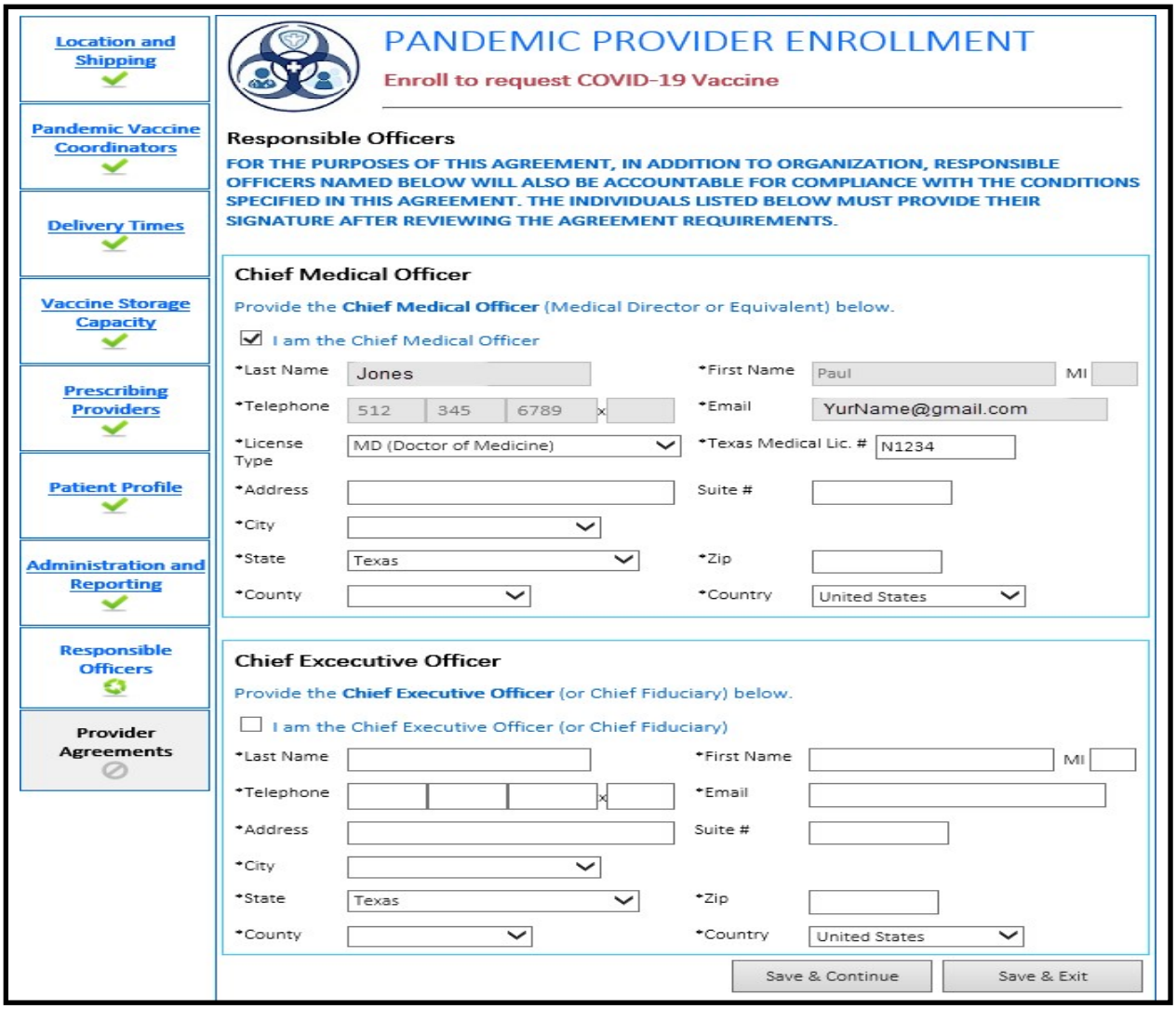

Figure 44: Responsible Officers

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.

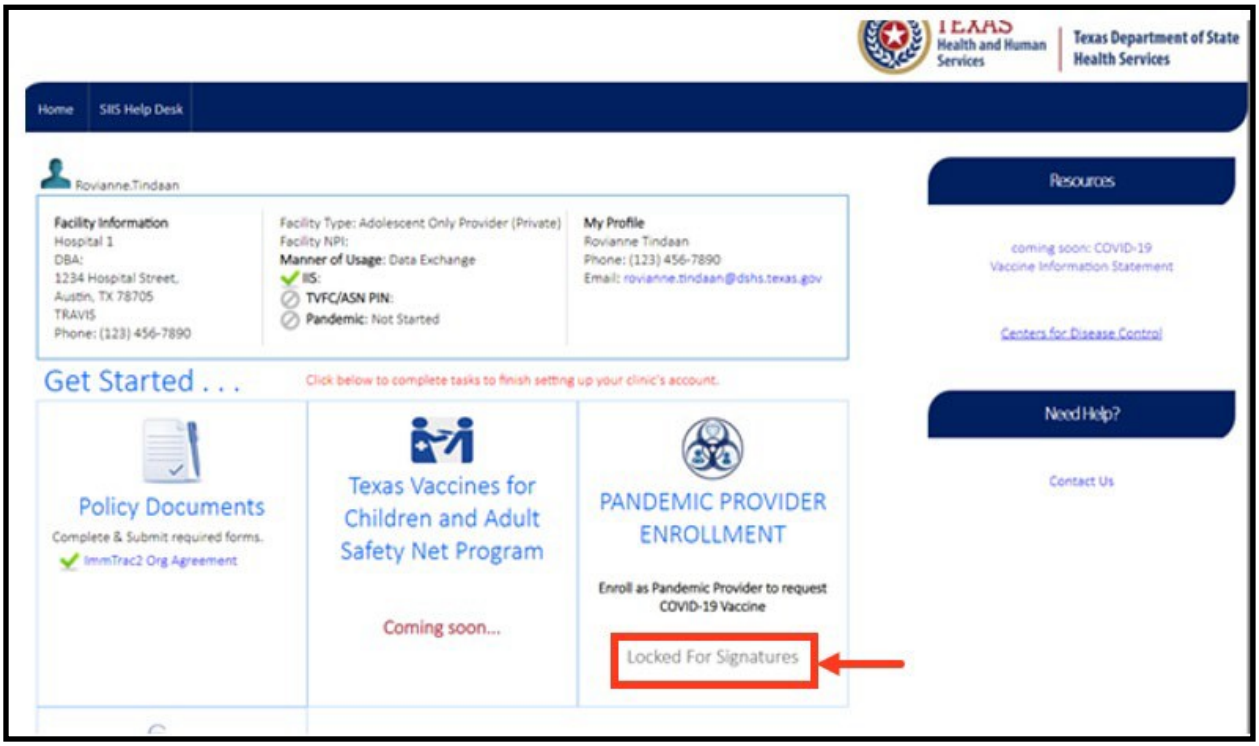

Figure 46: Locked for Signatures

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 dkvgsj

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

TEXAS Health and Human Services | Texas Department of State Health Services

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*.

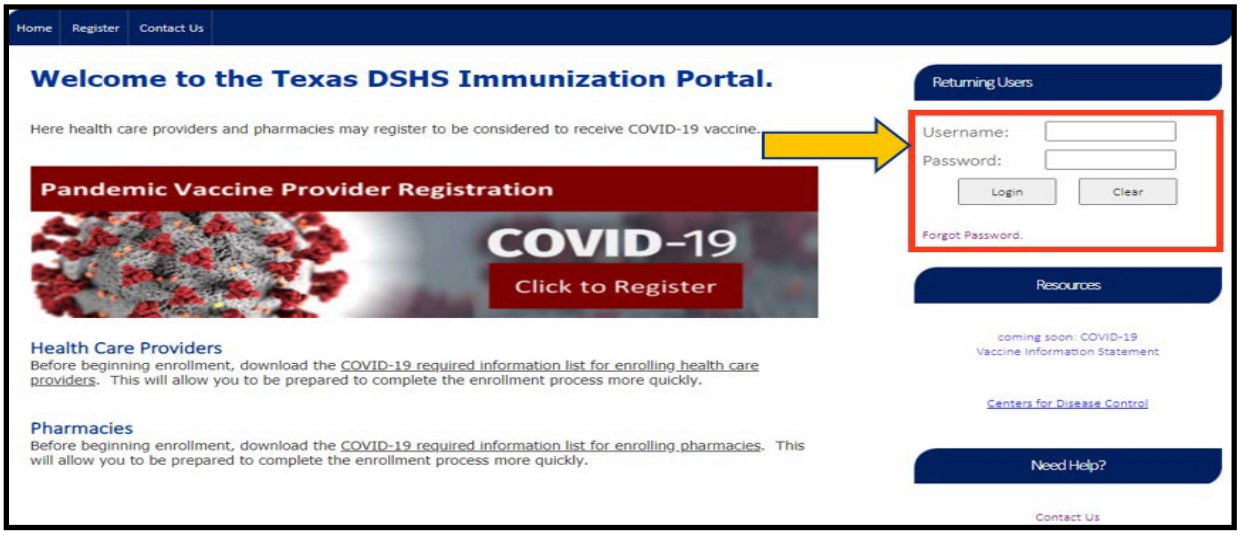

Figure 48: Logging in to DSHS Immunization Portal

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*.

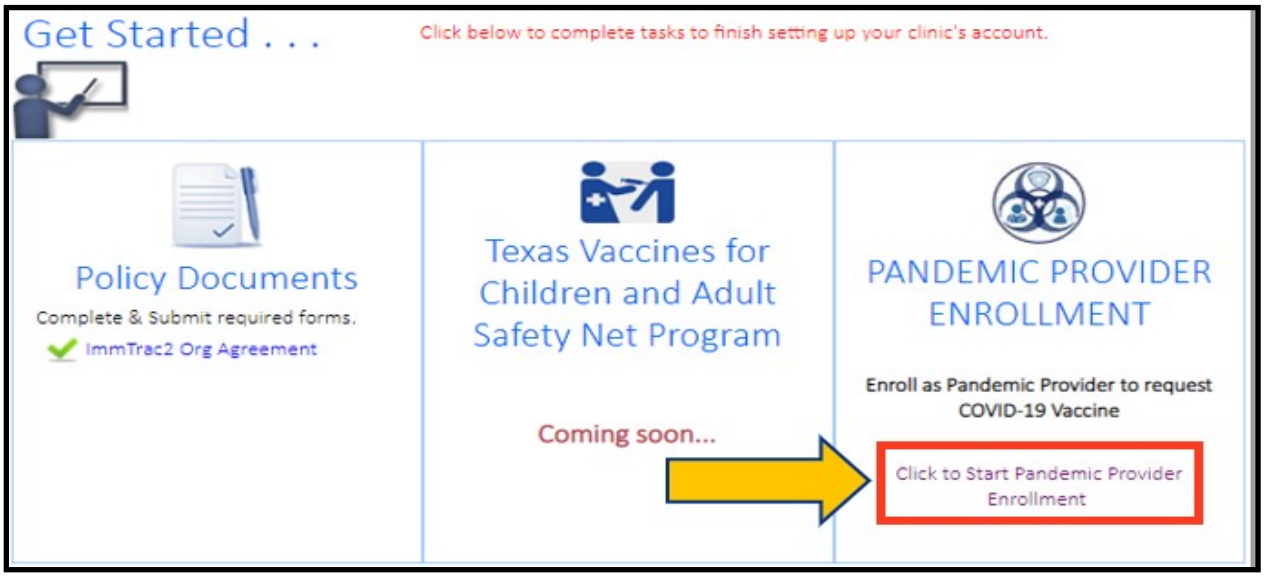

Figure 50: Start Pandemic Provider Enrollment

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:		

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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.	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] 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] 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.
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.	Organization must comply with CDC requirements for COVID-19 Vaccine management. Those requirements include the following: 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 Toolkit[4], 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 Toolkit[4]; 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

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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.[5]
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]

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[5] 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).

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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.*

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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? ☐ Yes; provide Organization name: _____ ☐ 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:

For official use only:

VTrckS 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**: _____*

***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.*

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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)

- ☐ Commercial vaccination service provider
- ☐ Corrections/detention health services
- ☐ Health center – community (non-Federally Qualified Health Center/non-Rural Health Clinic)
- ☐ Health center – migrant or refugee
- ☐ Health center – occupational
- ☐ Health center – STD/HIV clinic
- ☐ Health center – student
- ☐ Home health care provider
- ☐ Hospital
- ☐ Indian Health Service
- ☐ Tribal health
- ☐ Medical practice – family medicine
- ☐ Medical practice – pediatrics
- ☐ Medical practice – internal medicine
- ☐ Medical practice – OB/GYN
- ☐ Medical practice – other specialty
- ☐ Pharmacy – chain
- ☐ Pharmacy – independent
- ☐ Public health provider – public health clinic
- ☐ Public health provider – Federally Qualified Health Center
- ☐ Public health provider – Rural Health Clinic
- ☐ Long-term care – nursing home, skilled nursing facility, federally certified
- ☐ Long-term care – nursing home, skilled nursing facility, non-federally certified
- ☐ Long-term care – assisted living
- ☐ Long-term care – intellectual or developmental disability
- ☐ Long-term care – combination (e.g., assisted living and nursing home in same facility)
- ☐ Urgent care
- ☐ Other (Specify: _____)

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

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

Number of adults 19 – 64 years of age: _____ *(Enter "0" if the location does not serve this age group.)*
☐ Unknown

Number of adults 65 years of age and older: _____ *(Enter "0" if the location does not serve this age group.)*
☐ Unknown

Number of unique patients/clients seen per week, on average: _____
☐ Unknown
☐ 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)*
☐ 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):	☐ No capacity	☐ Approximately _____ additional 10-dose MDVs
Frozen (-15° to -25°C):	☐ No capacity	☐ Approximately _____ additional 10-dose MDVs
Ultra-frozen (-60° to -80°C):	☐ No capacity	☐ 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

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

CDC COVID-19 Vaccination Program Provider Profile Information

PROVIDERS PRACTICING AT THIS FACILITY *(additional spaces for providers at end of form)*

Instructions: *List below all licensed healthcare providers at this location who have prescribing authority (i.e., MD, DO, NP, PA, RPh).*

Provider Name	Title	License No.

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Figure 58: CDC COVID-19 Vaccination Program Provider Agreement – Page 8

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:

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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:

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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:

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