



# Texas Vaccines for Children (TVFC) and Adult Safety Net (ASN) Program Vaccine Transfer Authorization Form

**Guidance:**

Texas Vaccines for Children and Adult Safety Net (TVFC/ASN) providers are expected to maintain an adequate inventory of vaccine. The routine re-distribution of TVFC/ASN vaccine is not allowed. Vaccine transfers are limited to: short dated vaccine, withdrawal of a provider from the TVFC/ASN Program, or other (i.e., emergency, disaster, or equipment failure). When a vaccine transfer occurs, the proper cold chain must be maintained. When a provider needs to conduct a transfer of vaccine from one clinic to another, permission must be granted from the designated Department of State Health Services (DSHS) Public Health Region (PHR) prior to the vaccine transfer.

**Directions for use of this form:**

The TVFC/ASN providers must complete the Vaccine Transfer Authorization Form (EC-67) for each vaccine transfer. Each vaccine that is going to be transferred must be listed on a separate row. Transfer requests must be signed by the DSHS PHR and returned to the clinic before a transfer can be conducted. The Vaccine Transfer Authorization Form must be kept on file for a minimum of five (5) years as required by the TVFC/ASN Program and made easily accessible.

**Vaccine transfer in emergency situations (i.e., activation of the Emergency Vaccine Storage and Handling Plan):**

In the event that a provider must activate their Emergency Vaccine Storage and Handling Plan, providers must transfer vaccines to the alternative storage location identified in the plan. The PIN/Customer ID for the alternative location should not be included on the Vaccine Transfer Authorization Form if the alternative location is not a TVFC/ASN provider. Providers must contact the DSHS PHR by telephone prior to faxing the Vaccine Transfer Authorization Form in the event of an emergency. If the DSHS PHR cannot be contacted, the provider may transfer vaccine to the alternative storage location and must notify the DSHS PHR as soon as possible. A printout of the Tally Sheet from VAOS with the current vaccine counts pre-populated can be attached in lieu of handwriting all vaccine information on page 2.

**Vaccine Transferring From:**

**Vaccine Transferring To:**

**Reason for Transferring Request:  
(Check the appropriate reason)**

PIN/Customer ID: \_\_\_\_\_

PIN/Customer ID: \_\_\_\_\_

1. Short-Dated Vaccine

Facility Name: \_\_\_\_\_

Facility Name: \_\_\_\_\_

2. Withdrawal from the TVFC Program

Address: \_\_\_\_\_

Address: \_\_\_\_\_

3. Other (please specify):  
\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Fax: \_\_\_\_\_

Contact: \_\_\_\_\_

Contact: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

I hereby certify, subject to penalty under the False Claims Act (31 U.S.C. § 3730) and other applicable Federal and state law, that Vaccines for Children (VFC) and Adult Safety Net (ASN) vaccine dose transfers reported on this form has been accurately reported and conducted in conformance with VFC and ASN provisions for such transfers and further certify that all VFC and ASN transfers will maintain the proper cold chain as outlined in the TVFC/ASN Provider Manual.

Transferring Provider Name: \_\_\_\_\_

Transferring Provider Signature<sup>1</sup>: \_\_\_\_\_

Date: \_\_\_\_\_

Receiving Provider Name: \_\_\_\_\_

Receiving Provider Signature<sup>1</sup>: \_\_\_\_\_

Date: \_\_\_\_\_

DSHS PHR Representative Name: \_\_\_\_\_

DSHS PHR Signature: \_\_\_\_\_

Date: \_\_\_\_\_

<sup>1</sup> Provider or designee with authorization to act on behalf of the organization.





TVFC/ASN Vaccine Transfer Authorization Form (Continued)

Temperature Monitoring Information				
	Circle One:		Circle One:	
Temperature of originating refrigerator prior to departure:	_____ C / F _____		Time: _____	a.m. / p.m.
Temperature of originating freezer prior to departure:	_____ C / F _____		Time: _____	a.m. / p.m.
Temperature of transport container prior to departure:	_____ C / F _____		Time: _____	a.m. / p.m.
Temperature of transport container upon arrival:	_____ C / F _____		Time: _____	a.m. / p.m.
Temperature of destination refrigerator storage unit upon arrival:	_____ C / F _____		Time: _____	a.m. / p.m.
Temperature of destination freezer storage unit upon arrival:	_____ C / F _____		Time: _____	a.m. / p.m.
Contact your Responsible Entity for instruction, if temperatures during transport exceed recommended ranges.			Total Transport time: _____	Hr/Min.

**The total time for vaccine transport alone or vaccine transport plus clinic workday must not exceed a maximum of eight (8) hours (e.g., if transport to an off-site clinic is one hour each way, the clinic may run for up to six [6] hours).**