## Idaho Immunization Program VACCINE REPLENISHMENT REPORT

				VACCINE REPLENISH	WENT REPOR	<b>(1</b>		
Clinic/Provider Name:				_		PIN:		-
Guidance: VFC-enrolled providers are expected to maintain an adequate inventory of vaccine for their non-VFC eligible patients. VFC vaccine cannot be used as a replacement system for a provider's privately purchased vaccine inventory. There will be situations when a VFC-vaccine is inadvertently administered to a non-VFC eligible patient, or when private stock vaccine is administered to a VFC-eligible patient. Replenishment should be infrequent. The purpose of the Vaccine Replenishment Report is to track the replacement/replenishment of vaccine stock.								
Directions for Use:  When a provider has administered private stock vaccine to a VFC eligible patient or when VFC vaccine is administered to a non VFC eligible patient, the form must be completely filled out for each vaccine a child receives. Replacement doses must be replenished as soon as possible. The form must be faxed or emailed with provider accountablity reports to the Idaho Immunization Program at (208) 334-4914 of IP@dhw.idaho.gov. The provider's office needs to keep a copy of the completed form in the office records for a period of three years								
Dates covered:	1 1	to/	Immunization Contact:					
Vaccine Used	Lot Number	Patient Name/Patient Identifier	DOB	Insurance Status (VFC or private)	Date Administered	Reason appropriate stock of vaccine was not used	Lot Number of Dose Replaced	Date Vaccine Returned to Appropriate Stock
Example: MMR	1234Z	Jane B. Doe	6/26/2008	Private Insurance	7/8/2009	Insurance plan does not cover vaccines	5678A	8/3/2009
"I hereby certify, subject to penalty under the False Claims Act (31 U.S.C. § 3720) and other applicable Federal and state law, that VFC vaccine dose borrowing and replacement reported on this form has been accurately reported and conducted in conformance with VFC provisions for such borrowing and further certify that all VFC doses borrowed during the noted time period have been fully reported on this form."								
Provider Name:				Provider Signature:			Date:	

