Florida Vaccines for Children Program
Additional Information Form

Provider's Name:	
VFC PIN Number:	
Delivery Address:	
Telephone Number:	
Fax Number:	
Contact Person:	
Today's Date:	

NOTES: (use this section to notify a VFC Representative of any change in your shipping and mailing address, contact person,

Request Practice Name Change (*include a copy of the Recertification Form*)

PIN Number:	
New Practice	
Old Practice Name:	
Telephone Number:	
Fax Number:	
Contact Person:	

Request Practice Shipping Address Change

PIN Number:	
New Shipping	
Old Shipping	
Mailing Address:	
Telephone Number:	
Fax Number:	
Contact Person:	

Request Change Shipping/Delivery Hours: Enter all days and times you may receive vaccine. Specify if the clinic is closed during lunch hours and/or ***observed holidays***.

Monday		Tuesday		Wednesday		Thursday		Friday	
Open	**Closed**	**Open**	**Closed**	**Open**	**Closed**	**Open**	**Closed**	**Open**	**Closed**
Start Lunch	**End Lunch**	**Start Lunch**	**End Lunch**	**Start Lunch**	**End Lunch**	**Start Lunch**	**End Lunch**	**Start Lunch**	**End Lunch**

Holiday Closures:

Name of the person requesting the change:

Effective change date:

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Website: www.immunizeflorida.org