Attachment 1

Cover Page

Florida Department of

Health Immunization Section

DOH-RFA21-009

COVID-19 Vaccination

Title of Application:	
Legal Name of Applicant:	
Funding Amount Requested (annual):	
Area(s)/County to be Served:	
Name of Contact Person:	
Applicant Mailing Address:	
City, State, ZIP:	
Telephone Number:	
Fax:	
Email Address:	
Federal Employer Identification Number (FEID):	
Name and Title of Authorized Official:	
Signature of Authorized Official:	
Date:	
By signing above, you are attesting that: TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.	

Disclaimer – NOTE: The receipt of applications in response to this grant opportunity does not imply or guarantee that any one or all qualified applicants will be awarded a grant or result in a contract with the Florida Department of Health.
This grant opportunity is not subject to Section 120.57(3), Florida Statutes