450 W State Street 4th FL
Boise, Idaho 83702
(208) 334-5931

2016 PROVIDER POLICIES AND GUIDELINES ACKNOWLEDGMENT FORM

FACILITY INFORMATION	
Facility Name:	VFC Pin#:

By signing this form, I certify on behalf of myself and all immunization providers and staff at this facility, I have read and agree to comply with the Idaho Immunization Program 2016 Provider Policies and Guidelines.

In addition, I understand the 2016 Provider Policies and Guidelines supersedes any prior Idaho Immunization Program (IIP) policies and guidelines. I further understand that content and forms referenced may be updated or modified at any time. Updates and revisions will be communicated to my office through announcements in Idaho Immunization Reminder Information System (IRIS) and/or Important Notices published by the IIP and/or direct mail, email, and/or fax.

Medical Director or Equivalent	
Name (please print):	
Signature:	Date:

Primary Vaccine Coordinator	
Name (please print):	
Signature:	Date:

Back-up Vaccine Coordinator	
Name (please print):	
Signature:	Date:

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH