Please return your completed form via email to your regional approver.

If you do not know who that is, please contact help@imms.min.health.nz or call 0800 223 987

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| **Facility Set Up Form** |
| **Facility details section** |
| Health District | Click or tap here to enter text. |
| Facility name | Click or tap here to enter text. |
| Facility address | Click or tap here to enter text. |
| Facility ID (HPI ID) | Click or tap here to enter text. |
| Facility typePlease tick | [ ]  GP [ ]  Hospital [ ]  Marae [ ]  Community Pharmacy [ ]  Urgent Care Clinic [ ]  Residential Facility (e.g. Aged Care Facility, Residential Care etc.) [ ] Other |
| Vaccine Type |  | **Note: *GP providers should order these vaccines directly from Propharma*** |  |
| **COVID Contracted Providers** [ ]  Covid-19 Adult[ ]  Covid-19 Paeds[ ]  Covid-19 Infant | **Scheduled Vaccines**[ ]  Boostrix [ ]  Priorix (MMR)[ ]  Gardasil 9 (HPV9)[ ] Shingrix [ ]  Bexsero (MenB)[ ]  MenQuadfi (MenACYW) | **Whole-of-Life Providers**[ ]  Rotarix[ ]  Infanrix-Hexa [ ]  Infanrix-IPV[ ]  Prevenar 13[ ]  Act-Hib[ ]  Varilrix | Other Click or tap here to enter text. |
| **Delivery information** |
| Please provide the available delivery times for the facility, such as 7am to 5pm, Monday to Friday. |
| Available delivery times | [ ]  Mon | [ ]  Tue | [ ]  Wed | [ ]  Thu | [ ]  Fri |
|  |  |  |  |  |  |  |  |  |  |
| AM | PM | AM | PM | AM | PM | AM | PM | AM | PM |
| Regional Anniversary (i.e. Nelson etc) | Click or tap here to enter text. |
| Delivery Notes | Please add any comments which may assist the delivery driver |
| **Storage details** |
| Which of the following cold chain storage accreditation does the facility hold?  |
| Pharmacy License | Expiry Date: [DD/MM/YYYY] |
| Cold Chain Accreditation | Expiry Date: [DD/MM/YYYY] |
| Back-up fridge location | Click or tap here to enter text. |
| Is your facility signed off to provide off-site vaccinations? | Y [ ]  N [ ]  | Optional Comments |
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| **Contact details** |
| Please confirm at this vaccination facility who will be available and is authorised to receive the vaccine/consumables upon delivery, for example lead nurse, clinic manager.**Tick check box if inventory management system (portal) access is required**. |
| Primary contact | Name |  Confirm Name | Y [ ]  N [ ]  |
| Phone |  Confirm phone number/s |
| Email |  Confirm email address |
| Alternate/back up (at least one required) | Name |  Confirm Name | Y [ ]  N [ ]  |
| Phone |  Confirm phone number/s |
| Email |  Confirm email address |
| Name |  Confirm Name | Y [ ]  N [ ]  |
| Phone |  Confirm phone number/s |
| Email |  Confirm email address |
| Name |  Confirm Name | Y [ ]  N [ ]  |
| Phone |  Confirm phone number/s |
| Email |  Confirm email address |
|  | **Completed/signed by Health NZ Regional representative** |
| Name | Click or tap here to enter text. |
| Title | Click or tap here to enter text. |
| Signature | Click or tap here to enter text. |
| Please return your completed form via email to your regional approver. If you do not know who that is, please contact help@imms.min.health.nz or call 0800 223 987 |
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