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 type Please tick | | GP  Hospital  Marae  Community Pharmacy  Urgent Care Clinic  Residential Facility (e.g. Aged Care Facility, Residential Care etc.)  LMC  Plunket 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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