

## DSHS COVID-19 Vaccinator Program Vaccine Transfer Authorization Form

### **Guidance:**

COVID-19 Vaccine providers are expected to maintain an adequate inventory of vaccine. The routine re-distribution of COVID-19 vaccine is not allowed. Vaccine transfers are limited to: short dated vaccine, withdrawal of a provider from the COVID-19 Vaccine Program, or other (i.e., emergency, disaster, or equipment failure). When a vaccine transfer occurs, the proper cold chain must be maintained. When a provider needs to conduct a transfer of vaccine from one clinic to another, permission must be granted from the designated Department of State Health Services (DSHS) Central Office Representative (COR) prior to the vaccine transfer.

### **Directions for use of this form:**

The COVID-19 Vaccine providers must complete the Vaccine Transfer Authorization Form for each vaccine transfer. Each vaccine that is going to be transferred must be listed on a separate row. Transfer requests must be signed by the DSHS COR and returned to the clinic before a transfer can be conducted. The Vaccine Transfer Authorization Forms must be kept on file for a minimum of three years as required by the COVID-19 Vaccine Program and made easily accessible.

### **Vaccine transfer in emergency situations (i.e., activation of the Emergency Vaccine Storage and Handling Plan):**

In the event that a provider must activate their Emergency Vaccine Storage and Handling Plan, providers must transfer vaccines to the alternative storage location identified in the plan. The PIN/Customer ID for the alternative location should not be included on the Vaccine Transfer Authorization Form if the alternative location is not a COVID-19 Vaccine provider. Providers must contact the DSHS COR by telephone prior to faxing the Vaccine Transfer Authorization Form in the event of an emergency. If the DSHS COR cannot be contacted, the provider may transfer vaccine to the alternative storage location and must notify the DSHS COR as soon as possible. A printout of the Tally Sheet from VAOS with the current vaccine counts pre-populated can be attached in lieu of handwriting all vaccine information on page 2.

#### **Vaccine Transferring From:**

PIN/Customer ID: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Contact: \_\_\_\_\_

Email: \_\_\_\_\_

#### **Vaccine Transferring To:**

PIN/Customer ID (if applicable): \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Contact: \_\_\_\_\_

Email: \_\_\_\_\_

#### **Reason for Transferring Request: (Check the appropriate reason)**

- 1. Short-Dated Vaccine
- 2. Withdrawal from the COVID-19 Vaccine Program
- 3. Other (please specify) : \_\_\_\_\_

I hereby certify, subject to penalty under the False Claims Act (31 U.S.C. § 3730) and other applicable Federal and state law, that COVID-19 vaccine dose transfers reported on this form has been accurately reported and conducted in conformance with COVID-19 vaccine provisions for such transfers and further certify that all COVID-19 vaccine transfers will maintain the proper cold chain as outlined in the TVFC Provider Manual.

Provider Name: \_\_\_\_\_ Provider Signature<sup>1</sup>: \_\_\_\_\_ Date: \_\_\_\_\_

DSHS COR Name: \_\_\_\_\_ DSHS COR Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup> Provider or designee with authorization to act on behalf of the organization.

