Iowa HHS
Vaccines for Children Program
Vaccine Transferred Between VFC Providers

Facility Name:____ VFC PIN: ____________________

Telephone: (______)_________________________ Fax: (______)__________________________ Email: ______________________

The provider must assure VFC vaccine supplies are adequate to meet the needs of the provider's VFC-eligible patients and transferring vaccine will not prevent a child from receiving a needed vaccination. Transferring VFC vaccine to another VFC clinic should be the exception and providers should monitor vaccine inventory and vaccine usage patterns closely so vaccine transfer is an infrequent occurrence. **Vaccine transfers between VFC providers can occur only after receiving approval from the VFC Program by calling 1-800-831-6293.** Each vaccine must be listed on a separate row. This form must be faxed or emailed with each transfer of vaccine to the Iowa VFC Program at 1-800-831-6292 or IowaVFC@idph.iowa.gov and the provider should keep a copy of the completed form in their office records. Any inventory adjustments not submitted to the VFC Program for approval will be considered vaccine loss and may lead to restitution of VFC vaccine. VFC vaccine can only be transferred to a clinic enrolled in the VFC Program. Guidelines for transporting vaccine can be found in the Storage and Handling template on the Iowa Department of Public Health website. A signature is required below to affirm the provider understands VFC provisions related to vaccine transfers.

Vaccine Transferred	Number of Doses Transferred	NDC	Lot #	Date Transferred	Reason VFC Vaccine Was Transferred (Circle one)	Clinic Name Receiving Transferred Vaccine	Clinic VFC PIN Receiving Transferred Vaccine
					1. Vaccine will expire before it can be used 2. VFC order delayed 3. Other (specify______________________)		
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"I hereby certify, subject to penalty under the False Claims Act (31 U.S.C. § 3730) and other applicable Federal and state laws, that VFC vaccine doses transferred between providers reported on this form has been accurately reported and conducted in conformance with VFC provisions for such transfer and further certify that all VFC doses transferred during the noted time period have been fully reported on this form."

"I hereby certify I have stored vaccine according to CDC recommendations and have provided three months of temperature logs to the receiving clinic."

Clinic Contact Name:__________________________Clinic Contact Signature:_____________________________________Date: _______________________

Approved by State VFC Program Representative:_____________________________ Date: ________________