

CDC COVID-19 Vaccination Program Provider Agreement

Register to provide the COVID-19 Vaccine, please complete this section (Section A):

The Centers for Disease Control and Prevention (CDC) greatly appreciates your organization's participation in the CDC COVID-19 Vaccination Program.

Organization's responsible officers, Chief Medical Officer (or equivalent) and Chief Executive Officer (or chief fiduciary) must both complete and sign the CDC COVID-19 Vaccination Program Provider Requirements and Legal Agreement (Section A).

In addition, the CDC COVID-19 Vaccination Site - Provider Registration (Section B) must be completed for each vaccination location covered under the Organization listed in Section A.

Section A. COVID-19 Vaccination Program Provider Requirements and Legal Agreement

Organization Information

Organization's Legal Name:

* must provide value

TEST Health Care System

100 characters remaining

Number of affiliated vaccination locations covered by this agreement: (record the answer as an Integer)

* must provide value

4

Organization telephone number:

* must provide value

999-999-9999

Email (must be monitored and will serve as dedicated contact method for the COVID-19 Vaccination Program):

* must provide value

Test@TESTHealth.com

50 characters remaining

Organization street address:

2929 Test Rd.

100 characters remaining

Organization street address line 2:

100 characters remaining

Organizations address city:

Lansing

100 characters remaining

Organization address county:

* must provide value

Ingham

Organizations address state:

* must provide value

Michigan

Organization address zip code:

* must provide value

48915

RESPONSIBLE OFFICERS

For the purposes of this agreement, Responsible Officers named below will be accountable for compliance with the conditions specified in this agreement. The individuals listed below must provide their signature after reviewing the agreement requirements.

Chief Medical Officer (or Equivalent) Information

Last name:

* must provide value

ImCMOlastname

50 characters remaining

First name:

* must provide value

ImCMOfirst name

50 characters remaining

Middle Initial

50 characters remaining

Title:

* must provide value

MD

50 characters remaining

Licensure state:

* must provide value

Michigan

Licensure number:

* must provide value

98765432111

50 characters remaining

Telephone:

999-999-9999

Email:

ImCMO@Test.com

50 characters remaining

Street address :

2929 Test Rd

100 characters remaining

Street address line2:

100 characters remaining

City:

Lansing

100 characters remaining

County:

Ingham

State:

Michigan

Zip code:

48915

Chief Executive Officer (or Chief Fiduciary) Information

Last name:

* must provide value

ImCEOlastname

50 characters remaining

First name:

* must provide value

ImCEOfirstname

50 characters remaining

Middle Initial

A

50 characters remaining

Telephone:

999-999-9999

Email:

ImCEO@Test.com

50 characters remaining

Street address :

2929 Test Rd

100 characters remaining

Street address line2:

Suite 600

100 characters remaining

City:

Lansing

100 characters remaining

County:

Ingham

State:

Michigan

Zip code:

48915

Submit