

**VACCINES FOR CHILDREN PROGRAM (VFC)**  
**VFC Storage & Handling Site Visit - Acknowledgement of Receipt**

**Provider Name:** \_\_\_\_\_

**Site Visit No.:** \_\_\_\_\_

**Site Visit Reviewer:** \_\_\_\_\_

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

Thank you for participating in this VFC storage & handling site visit. Please take a few minutes to review your follow-up plan. The goal of this plan is to support you and your staff with successfully implementing the program and improving access to vaccines for VFC-eligible children within your practice.

To close out today's visit, please complete the provider acknowledgement section of the form below and keep this document for your records. Thank you for your continued dedication to the VFC program.

<b>TO BE COMPLETED BY SITE VISIT REVIEWER</b>	
I, _____, <i>(Site Visit Reviewer)</i> , acknowledge that a VFC storage & handling site visit was performed on _____ <i>(Visit Date)</i> and that I have provided a follow-up plan that includes any follow-up actions required (as applicable) and a list of all current VFC program requirements & recommendations assessed during the visit.	
<b>TO BE COMPLETED BY PROVIDER</b>	
<b>If the Medical Director (or equivalent) who signed the Provider Agreement is present:</b>	
I, _____ <i>(Medical Director)</i> , acknowledge that my practice took part in the VFC site visit noted above. I understand the findings of the visit and agree to take all required actions necessary in order to meet VFC program requirements (as applicable).	
<b>If the Medical Director (or equivalent) who signed the Provider Agreement is NOT present:</b>	
I, _____ <i>(Responsible Individual designated by MD)</i> , acknowledge that my practice took part in the VFC site visit noted above. I understand and will communicate to the medical director the findings of the visit and any required actions that must be taken by our office in order to meet VFC program requirements (as applicable).	
<b>Reviewer Signature:</b>	<b>Date:</b>
<b>Provider Signature:</b>	<b>Date:</b>