2017 Tdap Vaccine Usage Agreement
for San Francisco Department of Public Health (SFDPH)-Supplied Tdap Vaccine

Please complete and return by January 20 to: SFDPH, 101 Grove Street, Room 406, San Francisco, CA 94102, fax (415) 554-2579 or email tina.milton@sfdph.org

As a condition for receipt of Tdap vaccine from SFDPH,
I, as the physician, director, or other medical representative for

_____

Name of organization, or medical practice

Agree to the following terms:

1. **Twice yearly I <u>will</u> report accurate information in all fields of the SFDPH 2017 Tdap Vaccine Semi-Annual Usage Report**. In the case of my absence, the person named below will assume full responsibility for reporting accurate and complete information:

   Secondary person for completing reports: Name _____ Phone _____

   The Semi-Annual Usage Reports are due Friday, July 7, 2017, and January 5, 2018, and should include usage data for the period January 1 – December 31, 2017.

2. For each Tdap immunization given, **I will retain a record** that includes:
   - Vaccine manufacturer
   - Vaccine lot number
   - Date of immunization given
   - Vaccine expiration date
   - Patient's name and age category

   Records should be maintained for a period of at least 3 years. Do not send to SFDPH.

3. For the vaccine awarded, **my organization will <u>NOT</u> charge**:
   - The vaccinee or a third-party insurer any fee for the vaccine itself.
   - An administration fee higher than $26.03 per dose. Persons wishing to be vaccinated, but unable to pay an administration fee cannot be turned away.

4. My medical staff **will exercise medical judgement** in prescribing immunization for each person receiving Tdap vaccine and screen patients for contraindications before vaccine administration.

5. **Provide a copy of the "Tdap" Vaccine Information Statement** to each person receiving Tdap vaccine. Allow each person receiving Tdap vaccine adequate time for reading the information and asking questions before agreeing to be vaccinated. *To make sure you have the most recent vaccine information statements, please visit www.immunize.org/vis regularly.*

6. This SFDPH-supplied Tdap vaccine may be administered to all clinically eligible patients ages 7 and up, regardless of the time frame since their last Td. Special effort should be made to vaccinate pregnant women, close contacts of infants less than 1 year of age, and close contacts of pregnant women. For further information, review the CDC pediatric and adult vaccine schedules at http://www.cdc.gov/vaccines/schedules/

7. **Develop a workable inventory method** to ensure vaccine quality and distinguish SFDPH-supplied vaccines from other vaccines.

8. I agree to **adhere to all storage and handling guidelines**, as outlined in the Vaccine Management Plan binder and on the "Checklist for Safe Vaccine Storage and Handling." I agree to an annual site visit from an SFDPH Immunization Program staff member to assess vaccine administration and storage and handling practices.

9. I understand that this Tdap vaccine has been made available to prevent transmission of pertussis, especially to those who are at high-risk for complications from pertussis. Depending on the availability of Tdap vaccine, this program may end at any time.

Please Print Name _____
Physician, director, or other medical representative

SIGNATURE _____ Date _____
Physician, director, or other medical representative

Address _____

Telephone _____ Fax _____ Email _____