2017 SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
State-Purchased Tdap VACCINE APPLICATION

Please complete and return by Friday, January 20, 2017 to: SFDPH/CDPU, 101 Grove Street, Room 406, San Francisco, CA 94102 or fax to (415) 554-2579

1. Organization Name: _____

2. Is your organization non-profit or for-profit? _____

3. Population (#) directly served by your organization:

   Total # _____
   % population uninsured (please include Healthy SF Clients)? _____%

4. **Total # of doses you are requesting from SFDPH/CDPU for 2017:** _____

   Total # of doses you intend to secure from sources other than SFDPH/CDPU during 2017 (this will not affect your allocation) _____

5. Please indicate which type of refrigerator you use for vaccine storage:
   - ☐ Full-size, household-style, stand-alone refrigerator
   - ☐ Full-size, household-style unit with separate refrigerator and freezer compartments
   - ☐ Dormitory style unit with refrigerator and freezer compartments that share one external door
   - ☐ Full size, biologic/pharmaceutical grade, stand-alone refrigerator
   - ☐ Full size, biologic/pharmaceutical grade, refrigerator-freezer combo unit
   - ☐ Under-the-counter, biologic/pharmaceutical grade, stand-alone refrigerator
   - ☐ Under-the-counter, biologic/pharmaceutical grade, refrigerator-freezer combo unit

6. Do you have a data logger with a glycol probe, MIN/MAX setting, and alarm? Yes No
   Do you have a back-up digital thermometer with a glycol probe, MIN/MAX setting, and alarm? Yes No

   Please provide the calibration dates for each device (refer to calibration certificate or sticker on thermometer):
   Data logger calibration due date: _____
   Back-up digital thermometer calibration due date: _____

7. Do you record refrigerator temperatures twice daily, and always respond immediately to out-of-range temperatures?
   Yes No

8. Do you have back-up vaccine storage location you can easily access in the event of an emergency or power outage?
   Yes No

Vaccine Coordinator Name: _____

Title: _____

Signature: _____

Phone ( ) _____ **ext.** _____

Fax ( ) _____ **Email:** _____

Mailing address

_____

Street ***City*** ***zip***

You must complete the information below. **In the event that the person listed above is not available,** the persons named below will assume full responsibility **for meeting all terms of agreement with SFDPH/CDPU and sign all documents submitted to SFDPH/CDPU:**

Back-Up Vaccine Coordinator #1: _____

Title: _____

Signature: _____

Phone ( ) _____ **ext.** _____

Fax ( ) _____ **Email:** _____

Back-Up Vaccine Coordinator #2: _____

Title: _____

Signature: _____

Phone ( ) _____ **ext.** _____

Fax ( ) _____ **Email:** _____

Medical Director: _____

Signature: _____

Phone ( ) _____ **ext.** _____

Fax ( ) _____ **Email:** _____

License #: _____

Thank You

Complete and Return by Friday, January 20, 2017

SFDPH/CDPU ▪ 101 Grove Street, Room 408 ▪ San Francisco ▪ CA ▪ 94102 ▪ Phone (415)554-2830 ▪ Fax (415)554-2579