

## 2015 PROVIDER POLICIES AND GUIDELINES ACKNOWLEDGMENT FORM

<b>FACILITY INFORMATION</b>	
Facility Name:	VFC Pin#:
<p><i>By signing this form, I certify on behalf of myself and all immunization providers and staff at this facility, I have read and agree to comply with the Idaho Immunization Program 2015 Provider Policies and Guidelines.</i></p> <p><i>In addition, I understand the 2015 Provider Policies and Guidelines supersedes any prior Idaho Immunization Program (IIP) policies and guidelines. I further understand that content and forms referenced may be updated or modified at any time. Updates and revisions will be communicated to my office through announcements in Idaho Immunization Reminder Information System (IRIS) and/or Important Notices published by the IIP and/or direct mail, email, and/or fax.</i></p>	
<b>Medical Director or Equivalent</b>	
Name (please print):	
Signature:	Date:
<b>Primary Vaccine Coordinator</b>	
Name (please print):	
Signature:	Date:
<b>Back-up Vaccine Coordinator</b>	
Name (please print):	
Signature:	Date:

