Immunization, Assessment & Promotion (IAP) Program

# VACCINE CLINIC REQUEST FORM

**CLINIC REQUESTS MUST BE MADE A MINIMUM OF 7 BUSINESS DAYS IN ADVANCE**

## REQUESTER INFORMATION *(Please complete requester and clinic information sections and then save and email form to iapsupport@srhd.org)*

FIRST NAME | LAST NAME | PHONE | EMAIL

REQUESTING FACILITY OR ORGANIZATION | HOSTING LOCATION NAME & ADDRESS | CITY | ZIP

## CLINIC INFORMATION

Clinic type: ☐ Children ☐ Adults | Number of expected: Children | Adults

Proposed date #1 | Start time: ☐ a.m. ☐ p.m. | End time: ☐ a.m. ☐ p.m.

Proposed date #2 | Start time: ☐ a.m. ☐ p.m. | End time: ☐ a.m. ☐ p.m.

Health equity consideration:

## CHILDHOOD VACCINE REQUESTED

| | | | | |
|---|---|---|---|---|
| ☐ DTAP | ☐ HEP A | ☐ INFLUENZA | ☐ FLU-MIST (Live) | ☐ PCV-15 |
| ☐ DTAP/HEP B/IPV | ☐ HEP B | ☐ IPV | ☐ MENACWY | ☐ TDAP |
| ☐ DTAP/HEP B/HIB/IPV | ☐ HIB | ☐ MMR (Live) | ☐ MEN B | ☐ VARICELLA (Live) |
| ☐ DTAP/IPV | ☐ HPV9 | ☐ MMR/V (Live) | ☐ COVID-19 (Moderna) | ☐ Other: |

## ADULT VACCINE REQUESTED

| | | | | | |
|---|---|---|---|---|---|
| ☐ HEP A/B | ☐ IPV | ☐ MMR | ☐ SHINGLES | ☐ COVID-19 (Moderna) | ☐ JYNNEOS (MPOX) |
| ☐ HPV9 | ☐ INFLUENZA | ☐ PCV-20 | ☐ TDAP | ☐ | ☐ Other: |

Event type: | Interpretive services needed? ☐ Yes ☐ No | If yes, what language(s):

Will you need:
- Vaccinators: ☐ Yes ☐ No
- Support staff: ☐ Yes ☐ No
- Promotional materials: ☐ Yes ☐ No If yes: ☐ Flyer ☐ Social media ☐ SRHD website ☐ Translated? Language(s):

What can the requester contribute to support this clinic? *(recruitment, computers, tables, other logistics, CHWs, etc.)*

If vaccine liaison or pack-n-go, contact name/pick-up person: | Phone:

Pick-up time: ☐ a.m. ☐ p.m. | Name of preceptor or the lead vaccinator?

Drop-off time: ☐ a.m. ☐ p.m. | Phone #

**Please save and email this completed form to *iapsupport@srhd.org*.**

## TO BE COMPLETED BY IAP STAFF ONLY

Assigned team member: | Description of population to be served:

Has an assessment been completed to confirm that the target population is interested in this service? ☐ Yes ☐ No

Are CHWs needed? ☐ Yes ☐ No | If yes, describe need:

Location classification: | Method: | Vaccinator type:

# of vaccinators needed: | # of stations: | # of support personnel needed:

If using MRC, was request sent? ☐ Yes ☐ No ☐ N/A | PrepMod clinic? ☐ Yes ☐ No

Has communications been notified? ☐ Yes ☐ No ☐ N/A | Appointments required? ☐ Yes ☐ No

Pending for more details: ☐ Yes ☐ No | Wi-Fi hotspot? ☐ Yes ☐ No

Comments: | Laptop(s)? ☐ Yes ☐ No

☐ **If Pending**, notify AA so documents could be started and/or finalized.

☐ **Complete**, notify AA to update details on data sheet and calendar.

☐ AA has completed all tasks – **Clinic lead has updated staff info in PrepMod** (if needed) **and has notified all appropriate staff of clinic details.**

## AA CONFIRMATION

Clinic created in PrepMod? ☐ Yes ☐ No ☐ N/A | PrepMod clinic ID: | Data sheet created? ☐ Yes ☐ No

Clinic added to IMMs calendar with PrepMod clinic access link and PrepMod registration link? ☐ Yes ☐ No ☐ N/A

Pending for more info? ☐ Yes ☐ No | Clinic data spreadsheet updated? ☐ Yes ☐ No

☐ **Complete** – Received updates from IAP team member, updated all necessary items, attached completed clinic request form and data sheet to IMMs calendar and sent invite to clinic lead and backups.

Spokane Regional Health District assures nondiscrimination in accordance with Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act. To file a complaint or to request more information, reasonable accommodations, or language translations, contact 509.324.1501 or visit srhd.org.