Appendix B:
New inventory facility/site setup

This information must be provided to NPHS Te Whatu Ora five days in advance of any initial deliveries. Please use the following template to complete the information required to enable us to set up an inventory facility or site. Please take care and provide detail when completing the form, as accurate information is required to ensure successful delivery of vaccines and consumables.

Users who require access to the AIR vaccinator portal should use this link to find out more about onboarding: https://www.tewhatuora.govt.nz/our-health-system/digital-health/the-aotearoa-immunisation-register-air/sign-up-to-use-air/

Has the site been signed off by the Health District CE?		Please attach a copy of signed authorisation	
Y ☐	Please tick if yes	Y ☐	Please tick to confirm

Location details section	New set up – part one of four

A	Site	***Only complete Section A if a site is being set up.*** **Note: Sites are where vaccines are administered**
Site	**Health** District	Enter the Health District in which the vaccination facility/site is located
	Site name	Please provide the site name
	Site address	Please provide the delivery address. Please include floor number/building number/gate number if relevant.
	Confirm	Suburb and post code of this site
	City	Enter city in which this site is located
	Site type details	
	Please tick	Is this vaccination site also a facility? Y ☐ N ☐
	Vaccine type to be ordered	☐ Covid-19 ☐ Boostrix ☐ Priorix (MMR) ☐ Gardasil 9 (HPV9) ☐ Shingrix ☐ Bexsero (Men B) ☐ MenQuadfi (MenACYW)) ☐ Rotarix ☐ Infanrix-Hexa ☐ Infanrix-IPV ☐ Prevenar 13 ☐ Hiberix ☐ Varivax
	Site type Please tick	☐ GP ☐ Hospital ☐ Marae ☐ Off-Site ☐ On-Site ☐ Mobile or Pop-up Site *(short term vaccination site)* ☐ Mass Vaccination Event ☐ Permanent Vaccination Centre *(long term vaccination site)* ☐ Drive-Through ☐ School ☐ Community Pharmacy ☐ Urgent Care Clinic ☐ Residential Facilities (e.g. Aged Care Facility, Residential Care etc.) ☐ Place of Worship ☐ Workplace (Vaccination for staff and whanau) ☐ Bus ☐ Other:
	Equity focus	☐ Not applicable ☐ Māori ☐ Pacific Island ☐ Disability ☐ Mixed
	The following information relates to the Provider(s) responsible for the site.	
	Primary Provider name	Please provide the name of the primary provider
	Provider type	☐ Health District ☐ Occupational Health ☐ Community Pharmacy ☐ GP ☐ PHO ☐ Hauora ☐ Pacific Health Provider ☐ Urgent Care Facility ☐ Other If other, please add details
	Provider equity focus	☐ No Specific Equity Focus (General population) ☐ Māori ☐ Pacific Island ☐ Disability
	Collaborating provider name	Please provide the name of the collaborating provider (if applicable)
	Collaborating provider type	☐ Health District ☐ Occupational Health ☐ Community Pharmacy ☐ GP ☐ PHO ☐ Hauora ☐ Pacific Health Provider ☐ Urgent Care Facility ☐ Other If other, please add details
	Collaborating provider equity focus	☐ No Specific Equity Focus (General population) ☐ Māori ☐ Pacific Island ☐ Disability

Facility details section	New site set up – part two of four

B	Facility	***Please provide Facility or Associated Facility details.*** **Note: Facilities are where vaccines are shipped to, stored, and subsequently distributed to sites**
Facility	**Health District**	Please provide the Health District where the facility is located
	Facility name	Please provide the facility name if different to site name in Section A
	Facility type	Please provide the facility type, such as hospital, pharmacy, clinic
	Facility address	Please include suburb, city and postcode
	Delivery address (if different from facility address)	Please advise the delivery address - include floor number/building number/gate number if relevant.
	Facility ID (HPI ID)	What is this facility's ID (if unknown, state 'unknown')

Delivery information

Please provide the available delivery times for the facility, such as 7am to 5pm, Monday to Friday.

Available delivery times	☐ Monday		☐ Tuesday		☐ Wednesday		☐ Thursday		☐ Friday	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Delivery Notes	Please add any comments which may assist the delivery driver in successfully									

Storage, capacity, and contact details		New site set up – part three of four
C	**Which of the following storage accreditations does the facility provide?**	
Ultra-cold (-70C)	Y ☐ N ☐	If yes, please provide details of how many vials can be stored
Frozen (-20C)	Y ☐ N ☐	If yes, please provide details of how many vials can be stored
Cold chain (2-8C)	Y ☐ N ☐	If yes, please provide details of how many vials can be stored
Cold chain (2-8C) accreditation or Pharmacy License expiry date	Expiry Date: [DD/MM/YYYY]	
Back-up fridge location	[Please enter name and address of alternative location]	
Ambient	Y ☐ N ☐	If yes, please provide details of how many vials can be stored
Consumables	Y ☐ N ☐	If yes, please provide storage details
Is there a data logger reader at location?	Y ☐ N ☐	If yes, please provide details about brand/type
Pay per dose contract		
Pay per dose contract number		If this contract is a Pay per Dose contract – Please provide the contract number.
Regional Anniversary		In which region will you be observing Regional Anniversary days?
Pay per dose contract		
Named role	Please confirm the **named role** at this vaccination facility/site who will be available and is authorised to receive the vaccine/consumables upon delivery, for example lead nurse, clinic manager.	
Named role Name and contact phone number/s	**Name**	Confirm name
	Phone	Confirm phone number/s
Alternate Name and contact phone number/s of other team members who fit the named role	**Name**	Confirm name alternate 1
	Phone	Confirm phone number/s alternate 1
	Name	Confirm name alternate 2
	Phone	Confirm phone number/s alternate 2
Completed/signed by		
Name	Add name	
Title	Add title	
Signature	Insert signature	

Location details section		Facility moving – part four of four
D	***Only complete Section D if a facility is moving (e.g. due to an expired lease), and Cold Chain Accreditation can be transferred.*** **If Cold Chain Accreditation cannot be transferred, please complete a site closure and new site set-up form.**	
Facility Move Details	**Health District Approval**	Enter the name of the Health District representative who has approved the move to the new location, and vaccine storage and transportation arrangements.
	Can CCA be transferred from the old site to the new site?	Y ☐ N ☐ Tick **yes** if CCA has been confirmed to be transferred to the new location. Complete this section. Tick **no** if CCA has not been confirmed to be transferred to the new location and requires reassessment. Complete a site closure and new site set-up form.
	Address of new site	
	Is CCA expiry date current in Inventory Portal?	Y ☐ N ☐ If no, please update.
	Is back up fridge current in Inventory portal?	Y ☐ N ☐ If no, please update.