Appendix B:   
**New facility setup**

This information must be provided to Health New Zealand five days in advance of any initial deliveries.

Please take care and provide required detail when completing the form, as accurate information is required to ensure successful delivery of vaccines and consumables.

Please return your completed form via email to your regional approver.

If you do not know who that is, please contact help@imms.min.health.nz or call 0800 223 987

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| **Facility Set Up Form** | | | | | | | | | | | | | |
| **Facility details section** | | | | | | | | | | | | | |
| Health District | | Click or tap here to enter text. | | | | | | | | | | | |
| Facility name | | Click or tap here to enter text. | | | | | | | | | | | |
| Facility address | | Click or tap here to enter text. | | | | | | | | | | | |
| Facility ID (HPI ID) | | Click or tap here to enter text. | | | | | | | | | | | |
| Facility type Please tick | | GP  Hospital  Marae  Community Pharmacy  Urgent Care Clinic  Residential Facility (e.g. Aged Care Facility, Residential Care etc.) Other | | | | | | | | | | | |
| Vaccine Type | |  | | | | **Note: *GP providers should order these vaccines directly from Propharma*** | | | | | |  | |
| **COVID Contracted Providers**  Covid-19 Adult  Covid-19 Paeds  Covid-19 Infant | | | | **Scheduled Vaccines**  Boostrix   Priorix (MMR)  Gardasil 9 (HPV9) Shingrix   Bexsero (MenB)  MenQuadfi (MenACYW) | | | **Whole-of-Life Providers**  Rotarix  Infanrix-Hexa   Infanrix-IPV  Prevenar 13  Act-Hib  Varilrix | | | Other Click or tap here to enter text. | |
| **Delivery information** | | | | | | | | | | | | | |
| Please provide the available delivery times for the facility, such as 7am to 5pm, Monday to Friday. | | | | | | | | | | | | | |
| Available delivery times | Mon | | | | Tue | | Wed | | | Thu | | Fri | |
|  | |  | |  |  |  |  | |  |  |  |  |
| AM | | PM | | AM | PM | AM | PM | | AM | PM | AM | PM |
| Regional Anniversary (i.e. Nelson etc) | Click or tap here to enter text. | | | | | | | | | | | | |
| Delivery Notes | Please add any comments which may assist the delivery driver | | | | | | | | | | | | |
| **Storage details** | | | | | | | | | | | | | |
| Which of the following cold chain storage accreditation does the facility hold? | | | | | | | | | | | | | |
| Pharmacy License | Expiry Date: [DD/MM/YYYY] | | | | | | | | | | | | |
| Cold Chain Accreditation | Expiry Date: [DD/MM/YYYY] | | | | | | | | | | | | |
| Back-up fridge location | Click or tap here to enter text. | | | | | | | | | | | | |
| Is your facility signed off to provide off-site vaccinations? | Y  N | | | Optional Comments | | | | | | | | | |
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| **Contact details** | | | |
| Please confirm at this vaccination facility who will be available and is authorised to receive the vaccine/consumables upon delivery, for example lead nurse, clinic manager.  **Tick check box if inventory management system (portal) access is required**. | | | |
| Primary contact | Name | Confirm Name | Y  N |
| Phone | Confirm phone number/s |
| Email | Confirm email address |
| Alternate/back up (at least one required) | Name | Confirm Name | Y  N |
| Phone | Confirm phone number/s |
| Email | Confirm email address |
| Name | Confirm Name | Y  N |
| Phone | Confirm phone number/s |
| Email | Confirm email address |
| Name | Confirm Name | Y  N |
| Phone | Confirm phone number/s |
| Email | Confirm email address |
|  | | **Completed/signed by Health NZ Regional representative** | |
| Name | Click or tap here to enter text. | | |
| Title | Click or tap here to enter text. | | |
| Signature | Click or tap here to enter text. | | |
| Please return your completed form via email to your regional approver.  If you do not know who that is, please contact help@imms.min.health.nz or call 0800 223 987 | | | |
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