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

Health New Zealand
Te Whatu Ora

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

Health New Zealand
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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