Department of Health Services
Division of Public Health
F-02455 (02/2025)

State of Wisconsin
Vaccines for Children Program

Acknowledgement Page:

For Annual Re-Enrollment and Provider Agreement, and Vaccine Restitution Agreement

Facility Information

Facility name	VFC PIN

Street address

City	County	State	ZIP code

Phone number (Include area code)	Fax number (Include area code)

I understand that failure to adhere to this policy may result in suspension of our clinic's participation in the Vaccines for Children Program. (The person signing below accepts responsibility of adherence to this policy,and has authority to request repayment of dose-for-dose vaccine in the event of a loss.)

I confirm that I have read and agree to adhere to the following Wisconsin Immunization Program Provider Agreement and Restitution Policy.

Both boxes below must be checked for your re-enrollment to be completed.

☐ **Annual Re-enrollment and Provider Agreement (F-02454)**

☐ **Vaccine Restitution Policy (F-01744)**

Instructions: The official VFC registered health care provider signing the agreement must be a practitioner authorized to administer pediatric vaccines* under state law who will also be held accountable for compliance by the entire organization and its VFC providers with the responsible conditions outlined in the provider re-enrollment agreement.

***Note:** For the purposes of the VFC program, the term 'vaccine' is defined as any FDA-authorized or licensed, ACIP-recommended product for which ACIP approves a VFC resolution for inclusion in the VFC program.

Medical Director or Equivalent (If applicable)

Signature – Medical Director or equivalent	Date signed

Print name of Medical Director or equivalent

Please submit this completed form to the Wisconsin Immunization Program by fax, at 608-267-9493, or scan and email to VFC@wi.gov

Clear/reset the entire form