Ohio COVID-19 Vaccination Program Enrollment Checklist

Please use the following checklist to gather information needed ahead of time to complete the Ohio COVID-19 Vaccination Program Enrollment Forms.

Assure that you have your facility's Terminal Distributor of Dangerous Drugs (TDDD) license number as this will be requested when you initiate your agreements. Your TDDD can be found by visiting the State of Ohio Board of Pharmacy: https://elicense.ohio.gov/oh_verifylicense

COVID-19 Vaccination Program Enrollment Checklist:

- ☐ The **organization's** legal name, telephone, address, county, state, and ZIP code.
- ☐ The organization's **chief medical officer (equivalent)** Name, Title, Licensure Number, Telephone, Email, Street, City, County, State, and ZIP code.
- ☐ The organization's **chief executive officer (or chief fiduciary)** Name, Title, Licensure Number, Telephone, Email, Street, City, County, State, and ZIP code.
- ☐ The location's **primary and backup COVID-19 vaccine coordinator** contact information, including direct phone numbers and work email addresses.
- ☐ The **address for receipt of COVID-19 vaccine shipments** This is the location where the vaccine will be shipped. This address cannot be a PO Box.
- ☐ The **address where the COVID-19 vaccine will be administered**. This address must be the same as the vaccine shipment address indicated above. The **vaccine is not allowed to be redistributed or moved to other locations without prior approval from ODH.**
- ☐ The **days and times that** vaccine coordinators are available for receipt of **vaccine shipments.**
- ☐ Vaccination **provider type** for your location. Provider types include but are not limited to a pharmacy, public health provider, health center, hospital, medical practice, etc.
- ☐ **Settings** where this location will administer the COVID-19 vaccine. Locations include but are not limited to community centers, correctional facilities, long-term care facilities, hospitals, in-home, pharmacies, public health clinics, etc.
- ☐ **The approximate number** of patient/clients **routinely served** by the location.
  Categories will include:
  18 years of age or younger (**approximate)**
  19-64 years of age (**approximate)**
  65 years of age and older (**approximate)**

- Number of unique patient/clients seen per week on average **(approximate or not applicable for commercial vaccination service providers)** *Mark 'unknown' or '0' if your location does not serve a particular age group*

- [ ] The number of influenza vaccine doses administered during the peak week of the 2019–2020 influenza season *Mark 'unknown' or '0' if no influenza vaccine doses were administered by this location in 2019-2020.*

- [ ] **Population type(s)** served by this location
Population types include but are not limited to general adult/pediatric population, 65 and older, long-term care facility residents, health care workers, military, etc.

- [ ] **Reporting to ImpactSIIS**
Does your organization currently report vaccine administration data ImpactSIIS?
If so, list ImpactSIIS Facility ID?
If not, explain the method of reporting data to ImpactSIIS
  - *Please note, all COVID-19 vaccine providers who are not currently enrolled in the ImpactSIIS program will be asked to sign an ImpactSIIS agreement during the COVID-19 Vaccination Program Enrollment.*

- [ ] The **approximate number of 10-dose multidose vaccinations (MDVs)** your location can store during peak vaccination periods (e.g., during back-to-school or influenza season) for refrigerated, frozen, and ultra-cold temperatures.
  - If your location does not have one of the three listed cold chain parameter storage units, please mark 'no capacity.'

- [ ] **Storage unit details**: brand, model, and type of storage for storing COVID-19 vaccine (Example: CDC & Co/Red series two-door/refrigerator) *Important note:* your location's primary COVID-19 vaccine coordinator will be asked to sign an attestation for your storage units. All units listed must hold stable temperatures before any vaccine can be delivered to your location.

  Once you have submitted the form, an email will be sent to the individual listed as your primary COVID-19 vaccine coordinator for their signature. Forms cannot be reviewed by ODH until all required signatures have been submitted.

- [ ] Information for **providers practicing** at your facility (names of **all licensed healthcare providers at your location who have prescribing authority** such as MD DO NP PA RPh) who will be participating in COVID-19 vaccination efforts.

- [ ] You will be asked to list each provider name, title, license number. If no licensed healthcare providers at your location will be administering the vaccine, the medical director should be listed here.

- [ ] **Please note that the individual signing both the ODH Outbreak Response Immunization Initiative Agreement and the Impact SIIS Agreement should be legally able to bind an organization to the terms of a contract.**