2019 SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
HEPATITIS VACCINE PROGRAM APPLICATION FORM

Please complete this application form and return by **Friday, February 1, 2019** to:
SFDPH / CDPU, 101 Grove Street, Room 406, San Francisco, CA 94102
OR email to tina.milton@sfdph.org OR fax to (415) 554-2579

1. Organization Name: ____________________

2. Mission or Purpose of Your Organization: ____________________

____

3. Is your organization non-profit or for-profit? ____________________

4. Population (#) directly served by your organization:

Total # __________

% clients age 0-18 __________%

% clients ≥ age 19 __________%

Approximate % of your clients who are:

- Male __________%
- Female __________%
- Transgender __________%
- Men who have sex with men __________%
- Persons experiencing homelessness __________%
- Persons who inject street drugs __________%
- Persons with Chronic Hepatitis C infection __________%
- Persons with HIV infection __________%
- Persons from or frequent travelers to areas where chronic HBV is considered endemic (>8% infection rate) *These areas include Asia, Pacific Islands, Middle East, Eastern Europe and Russia, Sub-Sahara Africa, Amazon Basin, Caribbean, and indigenous populations of Alaska and Canada)*__________%

5. What percentage of your clients are uninsured and participate in Healthy San Francisco? __________%

What percentage of your clients are uninsured and do not participate in Healthy San Francisco? __________%

What percentage of your clients are privately insured? __________%

6.

	Adult Hep A	Adult Hep B	Combined Hep A & B
Total # of doses you are requesting from SFDPH/CDPU for 2019			
Total # of doses you intend to secure from sources other than SFDPH/CDPU for 2019 (this will not affect your allocation)			

7. Does your organization do serologic testing for: Hepatitis A? Yes No
Hepatitis B? Yes No
Hepatitis C? Yes No

8. Does your organization have access to the California Immunization Registry (CAIR)?
Yes No

9. Please indicate which type of refrigerator you use for vaccine storage:
Full-size, household-style, stand-alone refrigerator
Full-size, household-style unit with separate refrigerator and freezer compartments
Full size, biologic/pharmaceutical grade, stand-alone refrigerator
Full size, biologic/pharmaceutical grade, refrigerator-freezer combo unit
Under-the-counter, biologic/pharmaceutical grade, stand-alone refrigerator
Under-the-counter, biologic/pharmaceutical grade, refrigerator-freezer combo unit
Dormitory style unit with refrigerator and freezer compartments that share one external door *

10. Do you have a data logger with a glycol probe, MIN/MAX setting, and alarm?
Yes No
Do you have a back-up digital thermometer with a glycol probe, MIN/MAX setting, and alarm?
Yes No

Please provide the calibration dates for each device (refer to calibration certificate or sticker on thermometer):
Data logger calibration due date: ____________________
Back-up digital thermometer calibration due date: ____________________

11. Do you record refrigerator temperatures twice daily, and always respond immediately to out-of-range temperatures?
Yes No

12. Do you have back-up vaccine storage location you can easily access in the event of an emergency or power outage?
Yes No

** Dormitory style units are no longer acceptable for vaccine storage. Please contact the SFDPH IZ program directly if you are unsure about your unit's suitability for vaccine storage.*

SFDPH/CDPU ▪ 101 Grove Street, Room 406 ▪ San Francisco ▪ CA ▪ 94102 ▪ Phone (415)554-2955 ▪ Fax (415)554-2579 ▪ Email tina.milton@sfdph.org

Program Contacts

Person responsible for coordinating your organization's hepatitis program, meeting all terms of agreement with SFDPH/CDPU, and signing all documents submitted to SFDPH/CDPU:

Vaccine Coordinator Name: ______________________________

Title: ______________________________

Signature: ______________________________

Phone ( ) ______________________________ext. __________

Fax ( ) ______________________________Email: ______________________________

Mailing address

____

Street *City* *zip*

You must complete the information below. **In the event that the person listed above is not available**, the persons named below will assume full responsibility **for meeting all terms of agreement with SFDPH/CDPU and sign all documents submitted to SFDPH/CDPU:**

Back-Up Vaccine Coordinator #1: ______________________________

Title: ______________________________

Signature: ______________________________

Phone ( ) ______________________________ext. __________

Fax ( ) ______________________________Email: ______________________________

Back-Up Vaccine Coordinator #2: ______________________________

Title: ______________________________

Signature: ______________________________

Phone ( ) ______________________________ext. __________

Fax ( ) ______________________________Email: ______________________________

Medical Director: ______________________________

Signature: ______________________________

Phone ( ) ______________________________ext. __________

Fax ( ) ______________________________Email: ______________________________

License #: ______________________________