Wyoming Public Vaccine Program Provider Withdrawal Form

FACILITY INFORMATION		
Facility Name:		PIN:
Street:	City:	Zip:
First and Last Name of Person Completing this Form:		Title:
Email:		Phone:

Anticipated effective date:

Reason (select one)

- o Practice Closure
- o No longer seeing eligible patients
- o Unable to meet program requirements
- o Merging with another clinic; please provide clinic name:
- o Relocating out of state
- o Staffing issues
- o Discontinuation of WyVIP Program
- o Other (please specify): _____

Will this practice continue to provide vaccination services to patients? o Yes o No

As a reminder, reporting of vaccines administered in Wyoming to the Wyoming Immunization Registry (WyIR) is required, regardless of patient age or funding source of vaccine.

Please note that regardless of the effective date indicated on this form, until all publicly-supplied vaccine has been transferred out of the facility, you are responsible for the proper storage and handling of the vaccine. Any vaccine determined to be non-viable by the Immunization Unit due to improper storage, handling, or transportation of the publicly-supplied vaccine will be referred for replacement per the Vaccine Restitution Policy.

RESPONSIBLE PHYSICIAN/PRACTITIONER INFORMATION		
Last Name:	First Name:	
Title:	License Number:	
Signature:		Date:

Please complete all above information and return the form to wdh.pvpreporting@wyo.gov.

FOR IMMUNIZATION UNIT USE ONLY	
PIN of receiving facility of vaccine:	Date of Transfer:

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