2011

WASHINGTON STATE DEPARTMENT OF HEALTH
IMMUNIZATION PROGRAM

PROVIDER AGREEMENT FOR RECEIPT OF PUBLICLY SUPPLIED VACCINE

Agency Name: Kittitas County Public Health Department

On the attached page(s), please list the name, title, and specialty of all licensed health providers in your agency who are authorized to write prescriptions and may provide immunizations. (including yourself if you are a sole practitioner)

Vaccine Delivery Address		Mailing Address (if different)	
Street:	507 N. Nanum, Suite 102	Street:	
City:	Ellensburg	City:	
State:	WA	State:	
Zip Code:	98926	Zip Code:	
Telephone:	509.962.7515	Telephone:	
Extension		Extension:	
Fax:	509.933.8240	Fax:	
Email:	TIFFANY.BEARDSLEY@CO.KITTITAS.WA.US		

Days and times vaccine may be delivered: 9:00AM - 5:00PM, Monday-Friday

I agree to notify the state Department of Health immediately if my vaccine delivery address changes, and understand that this agency may be required to reimburse the state for vaccines that are wasted due to delivery failure resulting from an inaccurate address.

Type of Facility (please choose one):

- ☐ Private: All private sites (individual or group)
- ☐ Hospital
- ☐ Federal Qualified Health Center, Rural Health Clinic or Community/Migrant Health Center
- ☐ Dept. of Corrections
- ☐ Other Public Health: Those primarily serving adolescents
- ☐ Other Immunization Project: Tribal Clinics only
- ☒ Public Health Departments: LHJs
- ☐ Other:_____

As a condition for receiving publicly funded vaccines from the Washington State Immunization Program CHILD Profile this agency agrees to the **FEDERAL AND STATE REQUIREMENTS** attached.

I understand and accept the conditions of this agreement and agree to comply with these requirements on behalf of myself and all the practitioners associated with this agency. The state Department of Health may temporarily discontinue the provision of vaccine or may terminate this agreement at any time for failure to comply with these requirements. I may terminate this agreement at any time for personal reasons.

Mark Larson
Full name of person signing this agreement (please print)

MD - Health Officer
Title

Signature of Provider or Representative of the Facility

9/14/11
Date

RETURN COMPLETED FORM VIA FAX TO:
Washington State Department of Health
Adult Viral Hepatitis Prevention
Attn: Jessica Peterson
360-236-3400 (fax)

PROVIDERS WITHIN THE PRACTICE

Please print or type the names, titles, and specialties of licensed health providers in your agency's facilities who are authorized to write prescriptions and may provide immunizations. Attach additional copies of this sheet as needed.

Last Name, First, MI	Title (MD, DO, ND, NP, PA.) (Provider must have prescription writing privileges)	Specialty (Peds, Fam Med, GP, Other (specify)
Larson, Mark W	MD	ABFP

RETURN COMPLETED FORM VIA FAX TO:

Washington State Department of Health
Adult Viral Hepatitis Prevention
Attn: Jessica Peterson
360-236-3400 (fax)