Vaccines for Children Program Participation Withdrawal Form

Pin: ___________________________ Facility Name: ___________________________

What will be the last day your office plans to administer VFC vaccine? ___________________________

The Kentucky Immunization Program (KIP) understands that your office would like to withdraw from the VFC Program. Please fill out the following form in its entirety so that your withdrawal can be processed. Once completed please send to: e-mail at dph.kvp@ky.gov; by faxing to (502) 696-4923; or by mail to Kentucky Immunization Program, 275 East Main Street, HS2E-B, Frankfort, KY, 40621.

Thank you for your participation and all that you have done to serve the immunization needs of Kentucky. Official withdrawal from the VFC Program will be conditionally granted upon receipt of the completed form.

Why are you withdrawing from the VFC Program (please choose only the most appropriate response):

☐ Patient profile changed (e.g., decrease in volume of VFC-eligible patients)
☐ Office scope changed (e.g., no longer see children/adolescents, no longer see un-insured, etc.)
☐ Lack of staff (medical or administrative)
☐ Medicaid reimbursement issues
☐ Program administration issues (e.g., too much paperwork, etc.)
☐ Program equipment requirements (e.g., unable to purchase an approved storage unit or calibrated thermometers)
☐ Closing the practice
☐ Other (please write in your reason for leaving)

If your office is not closing, will you still be providing vaccines to your privately insured patients?

YES    NO    Please explain if you answered NO ___________________________

Physician’s Signature ___________________________ Date: ___________________________

Please complete and send a Return and Adjustment Form to show current inventory when submitting this form.

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