



VFC – Provider Change of Information Request Form

Please promptly submit this form to NM VFC to give notification of any changes in vaccine delivery or mailing addresses, vaccine personnel or other contacts, e-mail addresses, or your site’s telephone number(s)

Facility Name: _____ VFC Pin : _____

Primary Contact: _____
(Last Name) (First Name) (MI) (Title)

Add Personnel _____
to our VFC pin Last Name First Name email address

Remove Personnel _____
from our VFC pin Last Name First Name email address

Mailing Address: _____
(P.O. Box or Street Address) (City) (Zip)

Address for Vaccine Delivery: _____
(Street Address) (City) (Zip)

Telephone Number (_____) _____ - _____ Fax Number (_____) _____ - _____

Change Effective Date: _____

(Signature of Person Submitting This Form)

(Date)

(Printed Name and Title)

Please fax this form to VFC in Santa Fe (505) 827-1064 and to your regional immunization contact (reference fax number shown on VFC temperature logs).

Routing:
IZ Dept ____
NMSIIS ____
Rgn ____