SHOC Resource Form for Vaccine Events	**Requesting Agency Contact Information**

Date:	Time:	Event:
Requestor's Name:		Title:
Requestor's Organization:		
Phone #:	Mobile #:	Fax #:
Email Address:		

Vaccination Distribution Information

Vaccination Plan In-Place: ☐ Yes ☐ No	Implement Plan Within 5 days: ☐ Yes ☐ No
Ability to Vaccinate In-House: ☐ Yes ☐ No	Partnered w/Provider Vaccination: ☐ Yes ☐ No
Vaccine Storage Refrigerator: ☐ Yes ☐ No	Vaccine Storage Freezer: ☐ Yes ☐ No

Details of Vaccination Event (include vaccination event date and time, allocation group and any specific target populations, # to be vaccinated, any partners involved in event)

Requested Doses: ****There is no guarantee that all requested doses will be allocated**
No. of Staff to be Vaccinated:
Weekly Patient Census:

Ancillary Supply Kit will be included in vaccine shipment.

****NOTE**** If additional PPE is needed Fill out SHOC Resource Request Form

Are Educational Materials needed: ☐ Yes ☐ No

If **Yes**, list request by specific Language and Quantity: (i.e.…. English 20, Spanish 30, Haitian 40 etc.…)

Vaccine Dose Information	
Vaccine Dose 1st: ☐ Yes ☐ No Preferred Vaccine Type: ☐ Pfizer ☐ Moderna DATE:	Vaccine Dose 2nd: ☐ Yes ☐ No Preferred Vaccine Type: ☐ Pfizer ☐ Moderna DATE:
DelVAX: ☐ Yes ☐ No	Allocation Group: Choose an item.
Vaccine Storage Refrigerator: ☐ Yes ☐ No	Vaccine Storage Freezer: ☐ Yes ☐ No

Delivery Site Information	
Delivery Address *(include facility name, street, city, state and zip)*:	Drop Off Time:
Delivery Site POC (Point of Contact):	Email:
POC 24-hour Phone #:	POC Mobile #: POC Fax #:
Additional Information or Comments:	

POD Type/Method
For any doses that will be given outside your clinic/office walls and/or for which you are working with a partner (e.g., bringing a church group into your clinic or partnering with a community based organization or partner to deliver the vaccine in an off-site location), please complete the following:
POD Type/Method: ☐ Open ☐ Closed ☐ Drive-thru ☐ Walk-up ☐ Other
Target population list all that apply – (e.g., 65+, vulnerable population, home bound):

Date of event:	Partner name:
Number of doses:	Dose type: ☐ 1st dose ☐ 2nd dose

Remainder of Document Internal Processing	
Verification	
Vaccine Dose 1st: ☐ Yes ☐ No DATE:	Vaccine Dose 2nd: ☐ Yes ☐ No DATE:
DelVAX: ☐ Yes ☐ No (If Yes/Direct Ship/If No/SHOC Logistics)	Allocation Group: Choose an item.
Direct Ship: ☐ Yes ☐ No	SHOC Logistics: ☐ Yes ☐ No
Ability to fill request/Allocation Group	
☐ In entirety ☐ Partially ☐ Pending ☐ Redirected ☐ Other	
Comments (*why partial pending, redirected or other*)	
Send to DelVAX or SHOC Logistics for action	
Received by:	
Vaccine Unit Director Recommendation:	Date and Time:
Vaccine Unit Director Signature:	