

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: <input type="checkbox"/> Yes <input type="checkbox"/> No		Implement Plan Within 5 days: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ability to Vaccinate In-House: <input type="checkbox"/> Yes <input type="checkbox"/> No		Partnered w/Provider Vaccination: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vaccine Storage Refrigerator: <input type="checkbox"/> Yes <input type="checkbox"/> No	Vaccine Storage Freezer: Regular Ultra-Cold 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.)			
<div>Requested Doses:</div> <div>No. of Staff to be Vaccinated:</div> <div>Weekly Patient Census:</div> <div> **There is no guarantee that all requested doses will be allocated. </div>			
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: <input type="checkbox"/> Yes <input type="checkbox"/> No		Vaccine Dose 2nd: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Preferred Vaccine Type:		Preferred Vaccine Type: Pfizer Moderna		
DATE:		DATE:		
DelVAX: <input type="checkbox"/> Yes <input type="checkbox"/> No		Allocation Group:		
Vaccine Storage Refrigerator: <input type="checkbox"/> Yes <input type="checkbox"/> No		Vaccine Storage Freezer: Regular Ultra-Cold No		
Delivery Site Information				
Delivery Address <i>(include facility name, street, city, state and zip)</i> :			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: 1 st dose 2 nd dose		
Remainder of Document Internal Processing				
Verification				
Vaccine Dose 1st: Yes No		Vaccine Dose 2nd: Yes No		
DATE:		DATE:		
DelVAX: Yes No (If Yes/Direct Ship/If No/SHOC Logistics)		Allocation Group:		
Direct Ship: Yes No		SHOC Logistics: Yes No		
Ability to fill request/Allocation Group				
In entirety Partially Pending Redirected Other				
Comments <i>(why partial pending, redirected or other)</i>				
Send to DelVAX or SHOC Logistics for action				
Received by:				
Vaccine Unit Director Recommendation:		Date and Time:		
Vaccine Unit Director Signature:				

If Submit Form button does not work, please email completed form to: OEMS@Delaware.gov