

APPENDIX C: SMALLPOX VACCINATION CLINIC APPLICATION

Project Period January 1, 2004 – August 31, 2004

HOSPITAL NAME _____

Smallpox Vaccination Liaison Information:

Name: _____
 Title: _____
 Telephone: _____
 Facsimile: _____
 E-mail address: _____

Are you the hospital's Bioterrorism Coordinator? ___ Yes ___ No

[Note: A separate application needs to be submitted for each hospital-based clinic; for example, if a hospital network or CBPP elects to host 3 smallpox vaccination clinics at different hospitals then three applications will be needed.]

Site for smallpox vaccination clinic

Name of clinic _____
 Address of clinic _____
 Borough _____ Zip Code _____

Smallpox vaccination coordinator for clinic activities

Name _____ Title _____
 Address _____
 Contact information: Telephone _____ E-mail _____

Provide the names, titles and vaccination status of staff that will work in clinic, including the nurses, physician(s), administrator, registration clerk, and medical record coordinator. The number of nurses will depend on expected number of vaccinees (i.e., generally nurses are needed for screening and signing the consent form.)

Name	Title	Vaccinated against Smallpox in 2003 (Yes or No)	Certified to Administer Smallpox Vaccination (Yes or No)

Smallpox vaccination clinic activities will be conducted:

- As a separate clinic
- Combined with a primary care clinic
- Combined with employee health services clinic
- Other (describe) _____

Did your hospital conduct any smallpox vaccination mandatory education sessions in 2003?

Yes No

Did staff from the hospital attend the Train-The-Trainer sessions sponsored by DOHMH in February 2003?

Yes No

Briefly describe the implementation plan for your hospital's vaccination clinic. Do you expect any barriers for meeting the deliverables and requirements? (Use more space if necessary.)

Please describe how the clinic would follow-up with a vaccinee who did not return for the take check.

Please provide any additional comments.