Authorized Private Provider User Agreement

For Access to Florida SHOTS

(Florida State Health Online Tracking System)

Florida SHOTS is...

a centralized database for recording and tracking immunizations by s. 381.003, F.S

Completion of this agreement according to the following conditions and instructions is required for authorized access to Florida SHOTS.

TERMS OF AGREEMENT

PLEASE READ CAREFULLY. As a CONDITION for enrolling in the Florida State Health Online Tracking System, AUTHORIZED USERS AGREE TO:

1. Access Florida SHOTS to register or record immunization information for patients currently receiving vaccinations under their care.
2. Post DH Form 1478, Florida SHOTS Notification and comply with parent or legal guardian's request not to participate in Florida SHOTS by providing DH Form 1478, Opt-Out form to parents.
3. Allow parents to review information in their child's immunization record and correct data errors.
4. Enter accurate current and historical vaccination data in Florida SHOTS at the time of vaccination.
5. Accept and abide by all relevant state statutes concerning medical record confidentiality and Florida SHOTS access.
6. Ensure that facility staff accessing Florida SHOTS, as authorized by the licensed health care provider, adheres to all laws and regulations pertaining to use and access.
7. Safeguard user IDs and passwords against unauthorized use and assume responsibility for staff access to Florida SHOTS using the licensed provider's authorization.
8. Maintain user accounts such that only current authorized users have access to Florida SHOTS and all terminated staff are appropriately removed from access.
9. Contact Florida SHOTS to request new user IDs and passwords when necessary to prevent breaches of confidentiality.
10. Notify Florida SHOTS personnel immediately upon suspension or revocation of medical license.

In addition, for all authorized users of Florida SHOTS, it is UNDERSTOOD that:

1. Authorized administrators may assign staff access to Florida SHOTS and are solely responsible for managing such access.
2. Any authorized user can view the immunization information in the system for any patient in the system who is under their care, but can only modify vaccination information they provided.
3. The authorized licensed provider agrees to be solely liable and hold the Department of Health harmless for any breaches of confidentiality by the provider, or the provider's employees or agents.
4. Access to Florida SHOTS will be terminated upon license revocation or suspension, for breaches of confidentiality or failure to adhere to any portion of this agreement.

Complete and submit the form on page two according to the following instructions:

SECTION I - Licensed Health Care Provider Information

1. Provide the name of a health care provider licensed under chapters 458,459 or 464, F.S., and current medical license number. Provide VFC pin #, NPI and EMR if applicable.
2. Provide contact name, title, telephone and fax number, and email. The contact listed will become the account administrator.
3. The licensed provider must sign and date the agreement in the space provided. By signing the agreement, the authorized individual agrees to ensure that all staff accessing Florida SHOTS under his or her authorization will adhere to the same laws and regulations pertaining to access.

SECTION II - Provider Practice Facility Information

1. Provide the Organization name if you have multiple facilities.
2. Provide the facility name(s) and check the appropriate box for the facility type.
3. Provide the address, city, state, zip, county, phone, fax and site contact name for each facility where the provider practices and requests access.

SECTION III - Agreement Submission

1. Mail or fax this form to the address or fax number indicated. If you have any questions regarding completion of the form or about Florida SHOTS, please call the phone number provided.
2. Agreements will expire two years after activation. At that time, Contact the Department of Health, Bureau of Communicable Diseases for renewal.

Form DH-1479, 07/09
Stock Number 5744-HSD-1479-0

Authorized Private Provider User Agreement
For Access to Florida SHOTS
(Florida State Health Online Tracking System)

Licensed Health Care Provider (licensed under Chapters 458, 459 or 464, F.S.)

✓ **Upon approval of this agreement, providers will be issued user identification and passwords for access to Florida SHOTS. Providers may then allow their individual staff, who are authorized or approved following standard internal security procedures such as background checks conducted by the facility, to access Florida SHOTS using the provider's authorization. Providers are responsible for contributing to the immunization registry through data entry or electronic data transfer, ensuring staff adherence to confidentiality, managing staff turnover that requires system access termination, and managing new staff access through appointing an administrator at the site. Access to Florida SHOTS may be terminated for non-use or for failure to adhere to this agreement.**

Section I - Agreement by signing below, I agree to abide by all terms of this agreement.

Licensed Provider Name: Jane Myers License #: AP 5102

Signature: _____ Date: 12-15-2020

Vaccines for Children PIN# (If applicable): none NPI #: XX192565XX

Electronic Medical Records provider: none

Contact Name for this application: Suzanne Worth Title: Office Manager

Phone: 352-464-1600 Fax: 352-794-0010 Email: Jane@MyersAcuClinic.com

Section II - Provider Practice Facility Information

Please list information for your facility location(s) below. If your organization has more than two sites, additional sheets may be attached as necessary.

Organization Name (if applying as a group): _____

Name of Facility: Myers Acu-Clinic

Type of Facility: ☐ CMS ☐ CHC ☐ CHD
☐ Doctor's Clinic ☐ Hospital Clinic ☐ Hospital ER
☐ Military Medical Facility
☑ Other (please specify): Licensed Acupuncturist Office/Clinic

Address: 440 NW 12th Ave
City: St. Pete State: _____
Zip: 32449 County: Pinellas
Phone: 727-552-0123 Fax: 727-552-5512
Site contact name: Suzanne Worth

Name of Facility: _____

Type of Facility: ☐ CMS ☐ CHC ☐ CHD
☐ Doctor's Clinic ☐ Hospital Clinic ☐ Hospital ER
☐ Military Medical Facility
☐ Other (please specify): _____

Address: _____
City: _____ State: _____
Zip: _____ County: _____
Phone: _____ Fax: _____
Site contact name: _____

Section III-Agreement Submission

Please keep a copy for your files and mail or fax this agreement to:

Florida Department of Health
Bureau of Communicable Diseases
4052 Bald Cypress Way
Bin # A11
Tallahassee, Florida 32399-1719

Telephone: 877-888-SHOT (7468)
Fax: (850) 412-5801
Alternate Fax (850) 922-4195