



**Section 1 To be completed by the EMT-I-03 or EMT-Paramedic:**

I am requesting authorization under EMS Rule 8.8 for special authority to function as an influenza vaccine administrator. I verify that I have completed the Vermont Department of Health's (VDH) vaccinator training program and have met or will meet all the requirements of Rule 8.8.4 in the role as vaccinator. I understand that this special authority is limited to injectable influenza vaccine administration and I agree to follow the Department of Health prescribed clinic vaccination procedure for injectable vaccine administration. I furthermore understand that as a vaccinator, I am functioning outside my routinely authorized role as an EMT-Intermediate or Paramedic with my licensed EMS agency. I understand that my authorization to function as a vaccinator may be revoked by the Department of Health at any time without appeal. I acknowledge that in functioning as a vaccinator, I am functioning under the medical orders of the clinician named below rather than my EMS District Medical Advisor.

Name of EMT-I-03/Paramedic \_\_\_\_\_ Certification level  EMT-I-03  EMT-P  
 Certification number \_\_\_\_\_ Expiration Date \_\_\_\_\_ EMS agency affiliation \_\_\_\_\_  
 Phone \_\_\_\_\_ Email address \_\_\_\_\_  
 Vaccinator training method:  Self-study  In person Date of vaccinator training \_\_\_\_\_  
 I request VDH make my name and contact information available to:  public clinics  private clinics  neither.  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 2 To be completed by the head of the service listed above**

I understand that the applicant named above is applying for authorization to function as an influenza vaccine administrator. I verify that our organization can continue to meet our expected staffing requirements during times the applicant is functioning as a vaccinator and will work with the applicant to avoid conflicts between our organization's need for EMS coverage and when the applicant may be otherwise available to function as a vaccinator. I understand that I may revoke this statement by contacting the EMS Office. I understand that when functioning as a vaccinator, the applicant is functioning outside their normal EMS duties with our organization. I am not aware of any reason this applicant should be restricted from functioning as a vaccinator.

Vermont licensed EMS agency \_\_\_\_\_ Name of head of service \_\_\_\_\_  
 \_\_\_\_\_  
 Signature of head of service \_\_\_\_\_ Date \_\_\_\_\_

**Section 3 To be completed by the EMT-I-03/EMT-P OR the person responsible for the vaccination clinic**

Organization offering clinic \_\_\_\_\_ Anticipated clinic date(s) \_\_\_\_\_

**Section 4 To be completed by the person responsible for the vaccination clinic**

On behalf of this organization, I understand that the EMS certified person named on this form is applying for authorization to function as a vaccine administrator. I acknowledge that I am only permitted to engage EMS vaccinators in my specific clinic setting that are listed on the Department of Health's Approved EMS Vaccinator List at [www.vermontems.org](http://www.vermontems.org). I understand that this applicant has a limited role as a vaccinator and shall not be involved in other aspects of clinic operations such as vaccine transport, vaccine storage, initial patient screening or otherwise determining the qualifications of a person to receive the vaccine. I agree to follow the Vermont Department of Health prescribed clinic vaccination procedure for injectable vaccine administration. I acknowledge that this organization is responsible for assuring liability and workers compensation coverage when the vaccinator is functioning on our behalf. I agree to report any concerns about misconduct or unprofessional behavior to the Vermont Department of Health.

Organization offering vaccine clinic \_\_\_\_\_  
 Name of clinician providing medical orders for this clinic \_\_\_\_\_ Title \_\_\_\_\_  
 Name of official overseeing clinic operations \_\_\_\_\_ Phone \_\_\_\_\_  
 Email address of official \_\_\_\_\_ Anticipated date(s) of clinic \_\_\_\_\_  
 Signature of official \_\_\_\_\_ Date \_\_\_\_\_

**Section 5 To be completed by the Vermont Department of Health**

Date received \_\_\_\_\_ Disposition  Approved on date \_\_\_\_\_  Disapproved on date \_\_\_\_\_  
 Other \_\_\_\_\_  
 Approved by: Name \_\_\_\_\_ Signature \_\_\_\_\_

# Instructions for Completion of Vaccinator Application for EMT-Intermediate-03s and Paramedics

**NOTE:** An application to participate in a vaccination clinic is valid for a specific EMT-I-03/EMT-P for a specific organization on a specific date(s). If an EMT-I-03/EMT-P is not scheduled to assist at a particular clinic, but wishes to be put on the list of available vaccinators, complete Sections 1 and 2. Leave the remaining sections blank. The Vermont Department of Health's EMS Office will keep the application on file, photocopy it and use it when the EMT-I-03/EMT-P is assigned to specific public (Health Department-sponsored) clinics.

## **Section 1 To be completed by the EMT-I-03 or EMT-Paramedic:**

*Name of EMT-I-03/Paramedic:* the name of the applicant as it appears in the Vermont EMS certification database  
*Certification level:* the level the applicant is certified at by the Vermont Department of Health (VDH). The applicant must be a currently certified EMT-I-03 or EMT-P.

*Certification number and Expiration Date:* as issued by VDH

*EMS agency affiliation:* an applicant who is affiliated with more than one licensed EMS agency should generally enter his or her primary affiliation.

*Phone and Email address:* how the applicant would like VDH or clinic organizers to contact him/her

*Vaccinator training method:* check one box to indicate how the applicant received vaccinator training

*Date of vaccinator training:* the date the applicant completed the vaccinator training

*Contact information:* If an applicant wishes to have public or private clinics have access to his/her contact information, check the appropriate box(es). If the applicant does not want contact information shared, check the box marked "neither."

*Signature and Date:* sign and date the application

## **Section 2 To be completed by the head of the service**

*Vermont licensed EMS agency:* the applicant must have affiliation with a licensed EMS agency to be eligible for this program

*Name of head of service:* the name of the office of service as it appears in the Vermont EMS database. If this has changed, the agency must notify the Vermont Department of Health's EMS in writing before a new head of service can be recognized.

*Signature of head of service and Date:* as above

**A head of service may revoke this statement simply by contacting the Vermont EMS Office.**

## **Section 3 To be completed by the EMT-I-03/EMT-P OR the person responsible for the vaccination clinic**

**NOTE:** If the EMT-I-03/EMT-P knows which clinic he or she will work at, he/she should complete this section. If that is not known or if the EMS provider wishes simply to be available for future public clinics, leave this section for VDH to complete.

*Organization offering vaccine clinic:* If an EMT-I-03/EMT-P wishes to participate in vaccination clinics for more than one organization, the applicant must complete a separate form for each organization.

*Anticipated date(s) of clinic:* the specific dates (not just month and year) when the clinic is anticipated to take place. If a clinic is re-scheduled, there is no need to submit an additional application. If the applicant wishes to participate in additional clinics that are scheduled after this application is submitted to VDH, the EMT-I-03/EMT-P will need to submit a new application.

## **Section 4 To be completed by the person responsible for the vaccination clinic**

**NOTE:** If this is a private clinic, have the person responsible for the clinic complete this section and then submit it to the Vermont Department of Health's EMS Office.

*Name of clinician providing medical orders for this clinic:* this must be a physician.

*Title:* MD or DO

*Name of official overseeing clinic operations:* the person responsible for the administrative (not medical) operations of the clinic

*Phone and Email address of official:* how VDH may contact the official regarding vaccination clinics

*Signature of official and Date:* as above

## **Section 5 To be completed by the Vermont Department of Health**

*Date received:* when VDH received the application

*Disposition:* VDH indicates here whether **this** EMT-I-03/EMT-P is approved to participate as a vaccinator for **this** organization on **this/these date(s)**

*Approved by:* name and signature of person authorized by VDH to make this decision

For answers to any additional questions, contact the Vermont Department of Health's EMS Office EMS at 800-244-0911 or 802-863-7310 (fax 802-863-7577). PO Box 70, 108 Cherry St., Burlington, VT, 05402.