



Prequalification Form for Organizations Requesting Seasonal Influenza Vaccine

Return this form on or before August 24, 2009 to:

Attention: UIIP Coordinator
Universal Influenza Immunization Program
Ministry of Health and Long-Term Care
Public Health Division
Public Health Protection & Prevention Branch
5700 Yonge St., 8th Floor
Toronto ON M2M 4K5

(Company mailing address)

1. I/we acknowledge the publicly-funded influenza vaccines that are received as a part of the Seasonal Universal Influenza Immunization Program (seasonal UIIP) will only be administered to persons aged 6 months or older who live, work or attend school in Ontario, unless medically contraindicated based on an individual assessment;
2. I/we shall ensure that the publicly-funded influenza vaccine will be administered **free of charge** to all eligible recipients (vaccine recipients should not pay for influenza immunization) regardless of whether:
 - a. it is administered by our organization; or
 - b. we are retained by an organization to administer the vaccine;
3. I/we shall ensure that the publicly-funded influenza vaccine will be administered to all eligible recipients as recommended by the National Advisory Committee on Immunization (NACI) *Statement on Influenza Vaccination for the 2008-09 Season*, or the 2009-2010 season to the extent that notice is provided to you of this requirement (which includes healthy pregnant women and children 6 months of age or older), unless medically contraindicated based on an individual assessment;
4. I/we understand and agree to follow all Ministry of Health and Long-Term Care ("Ministry") cold chain requirements for storage and handling of publicly-funded vaccine as detailed in the **Vaccine Storage and Handling Guidelines (2006 or as current)** document. Premises storing publicly-funded vaccines will require a documented cold chain inspection of their vaccine refrigerator that meets the requirements for vaccine storage and handling prior to being provided with publicly-funded vaccines;
5. I/we understand that our vaccine refrigerator(s) must meet the following requirements:
 - located within the health unit's jurisdiction where the vaccine is to be ordered and must be inspected by the same health unit;
 - physically located within our organization's premises;
 - monitored by our employees;
 - not located in a private dwelling house; and
 - not located in a community pharmacy.
 Note: leasing of space inside a refrigerator (i.e. shelves in a refrigerator) is not permitted;
6. I/we understand that if our organization provides occupational health services to another organization or if our organization owns or is owned by a long-term care home (LTCH), the publicly-funded influenza vaccine will only be used for immunization clinics which are held within the physical premises of that organization / LTCH. I/we will not use the vaccine refrigerator to store publicly-funded influenza vaccine for other influenza community clinics held by our organization;
7. **I/we will be planning to host influenza immunization clinics in the following jurisdictions and will require a cold chain inspection on the refrigerators listed below.** I/we understand that if our organization does NOT have a refrigerator in the health unit's jurisdiction, we will not be able to obtain vaccine from the health unit and will not be able to provide influenza immunization clinics in that jurisdiction. I/we agree to only store publicly-funded influenza vaccine in the refrigerators listed below (vaccines are not to be stored in refrigerators located in private dwelling houses). *(Attach an additional sheet if extra space is required).*

Vaccine Refrigerator 1			
Name of Organization			
Name of Contact (First name, Last name)		Telephone ()	
Number	Street Name		
City	Province	Postal Code	

Vaccine Refrigerator 2			
Name of Organization			
Name of Contact (First name, Last name)		Telephone ()	
Number	Street Name		
City	Province	Postal Code	

I/we understand that this information will be released to the health unit in order to conduct the required cold chain inspections.

8. I/we will ensure that the vaccine is maintained under the required cold chain conditions at all times and the *Influenza Vaccine Storage and Handling Guidelines for Health Care Agencies and Workplaces* fact sheet is followed;

I have read this page (INITIALS):

9. I/we agree to reimburse the Ministry for the cost of any part of the vaccine inventory that is lost due to, what is in the Ministry's sole opinion, a preventable cold chain incident;
10. Organizations **within** the "M" postal code: I/we agree that vaccine provided by the Ontario Government Pharmaceutical and Medical Supply Service (OGPMSS) will be administered in clinics held within Toronto's geographical boundaries (**within** the "M" postal code);
11. Organizations **outside** the "M" postal code: I/we agree that vaccine provided by the health unit will be administered in clinics held within that health unit's geographical boundaries;
12. I/we agree that publicly-funded influenza vaccine will NOT be taken outside the jurisdictional area of the health unit that provided the vaccine (or outside Toronto, for vaccine obtained from OGPMS);
13. I/we agree to act in accordance with any direction in writing from the Ministry respecting the timing and manner of immunization of high risk persons and immunization of the general population;
14. I/we agree that **we will not hold influenza immunization clinics until notified to do so by the Ministry**. The Ministry will notify electronically all organizations who have prequalified for the seasonal UIIP, when clinics may be held. (Note that the start date for clinics for the 2008-2009 seasonal UIIP season was November 12, 2008).

**ALL organizations (except Long-term care homes and retirement homes) must complete 15a.
Long-term care homes and retirement homes must complete either 15a. or 15b. (whichever is applicable)**

15a. I/we confirm that a physician will provide medical direction to the program and be responsible for the administration of the influenza vaccine ("affiliated physician"). The influenza vaccine will be administered by a regulated health professional under the *Regulated Health Professions Act, 1991*, under appropriate medical directives consistent with requirements as set out by the College of Physicians and Surgeons of Ontario (CPSO), the *Medicine Act, 1991*, and the *Regulated Health Professions Act, 1991*. The affiliated physician's OHIP billing number or CPSO Registration Number as well as contact information are provided below.

PRINT in block letters using black or dark blue ink.

Affiliated Physician (<i>First Name, Last Name</i>)		OHIP Billing Number	CPSO Registration Number	
Business address				
Number	Street name	City	Province	Postal Code
Telephone Number ()		Facsimile Number ()		

15b. I/we do NOT have a physician who will provide a medical directive to the program. Our organization will obtain direct medical orders from each resident's physician. The influenza vaccine will be administered by a regulated health professional under the *Regulated Health Professions Act, 1991*, under appropriate direct medical orders consistent with requirements as set out by the College of Physicians and Surgeons of Ontario (CPSO), the *Medicine Act, 1991*, and the *Regulated Health Professions Act, 1991*. I/we understand that the health unit can audit these direct medical orders;

(Check here) This applies to our organization.

16. I/we confirm that the organization administering the vaccine has put in effect and shall maintain, at its own costs and expense, a policy of comprehensive general liability insurance providing coverage for a limit of not less than five million dollars Canadian Dollars (\$5,000,000.00 CAD) for each occurrence that will protect and save harmless our organization and employees and Her Majesty the Queen in right of Ontario in the case of an adverse event or lawsuit related to the storage, handling or administration of the influenza vaccine by our organization. The policy of insurance must:
 - be effective during the time period from October 1, 2009 to March 31, 2010;
 - indicate the effective and expiry dates;
 - indicate the name of our organization;
 - name Her Majesty the Queen in right of Ontario as an additional insured; and
 - be mailed **together (sent at the same time)** with the signed and completed *Prequalification Form* to the Ministry to the attention of: UIIP Coordinator, Universal Influenza Immunization Program, Ministry of Health and Long-Term Care, Public Health Division, Public Health Protection & Prevention Branch, 5700 Yonge St., 8th Floor, Toronto ON M2M 4K5 by **August 24, 2009**.

NOTE: Ontario and federal government programs are NOT required to provide a copy of insurance policy to the Ministry;

17. I/ we understand that statements of self-insurance will not be accepted as proof of liability insurance;
18. I/we understand that the *Prequalification Form* and proof of insurance received after August 24, 2009 will NOT be processed and/or prequalification packages received by fax or any other kind of electronic transmission will be NOT be accepted;
19. I/we understand that it is our responsibility to ensure that this *Prequalification Form* is complete (this includes initialling the bottoms of pages 1, 2 and 3 of this *Prequalification Form*) and the proof of insurance policy is submitted along with the *Prequalification Form* to the Ministry. The Ministry will not process incomplete prequalification packages (which must include the *Prequalification Form* and insurance policy) and will not contact us if the prequalification package is incomplete;

I have read this page (INITIALS):

I/we understand that the Ministry will **not** notify our organization if our prequalification package was received;

20. I/we understand that once the Ministry receives our *Prequalification Form*, the Ministry will not accept any amendments to our *Prequalification Form*.
21. I/we agree that the Ministry and its officers, employees and agents shall not be liable to me/us or any of our personnel for any costs, losses, claims, liabilities and damages howsoever caused (including any incidental, indirect, special or consequential damages, injury or any loss of use or profit) arising out of or in any way related to our participation in the Universal Influenza Immunization Program (UIIP);
22. I/we agree to indemnify and hold harmless the Ministry from and against any and all liability, loss, costs, damages and expenses (including legal, expert and consultant fees), causes of action, actions, claims, demands, lawsuits or other proceedings, by whomever made, sustained, incurred, brought or prosecuted, in any way arising out of or in connection with the administration of the vaccine, unless solely caused by the negligence or wilful misconduct of the Ministry;
23. I/we acknowledge that receipt of vaccine is subject to providing the Ministry with any and all information as may be requested by the Ministry and to provide that information to the Ministry as required in the time-line and manner required by the Ministry. This information will be used by the Ministry for program evaluation, planning and other purposes as authorized under the *Health Protection and Promotion Act*, and shall not be used or disclosed for any other purpose;
24. I/we understand that the following information must be reported to the Ministry **within ten (10) working days** of the immunization clinic on the *Vaccine Utilization Report Non-Reimbursable Clinics* form, the *Vaccine Utilization Invoice Reimbursable Clinics* form and/or the *Vaccine Utilization Invoice Pharmacy Based Clinic* form for all vaccine recipients at the clinic:
 - All vaccine doses administered and wasted by lot number; and
 - Number of doses administered by gender, age and priority grouping breakdown (high priority group or general population).This information will be used by the Ministry for program evaluation, planning and other purposes as authorized under the *Health Protection and Promotion Act*, and shall not be used or disclosed for any other purpose;
25. I/we agree that reimbursement for administering influenza vaccine will only be provided to the following authorized public clinic providers: health units, Long-Term Care Homes, public hospitals, Community Health Centres, Community Care Access Centres and pharmacies provided that **ALL** of the following conditions are met:
 - *For pharmacies only:* pharmacy based clinics must be held within the physical boundaries of the pharmacy;
 - Open to the public (i.e. open and accessible to any eligible vaccine recipient who lives, works or attends school in Ontario);
 - Widely advertised in the community (i.e. pre-event promotion in areas visible/accessible to **all** members of the public);
 - Publicly-funded vaccine must be used;
 - Publicly-funded vaccine must be both obtained and administered within the jurisdictional boundaries of the same health unit;
 - Influenza immunization must be provided free of charge to the vaccine recipients; and
 - The Ministry must not be billed for these immunizations through another mechanism.
26. I/we understand that any *Vaccine Utilization Invoice Reimbursable Clinics* forms and/or *Vaccine Utilization Invoice Pharmacy Based Clinic* forms submitted that do not have all fields completed or are missing the Authorized Signing Officers signatures will not be processed and will not be eligible for reimbursement.
27. I/we agree to obtain from each recipient, as a condition for receiving the vaccine, a **written consent** to receive the vaccine and to have the organization and/or attending regulated health professionals under the *Regulated Health Professions Act, 1991*, disclose to the Ministry such personal information of the recipient as the Ministry requires for health program evaluation and/or health planning purposes. Information disclosed to the Ministry is subject to the *Personal Health Information Protection Act, 2004* and the *Freedom of Information and Protection of Privacy Act*, as applicable;
28. I/we agree that a written record of the influenza immunization, which includes our organization's contact information (name of organization, contact telephone number, address) will be provided to each vaccine recipient;
29. I/we agree to keep a record of every dose of influenza immunization administered. The record shall indicate the following: the time and date that the vaccine was administered, the name of the vaccine, lot number and the name of the vaccine recipient;
30. I/we agree to retain the records as noted in paragraph 29 and written consents as noted in paragraph 27 for not less than 5 years ("retention period") and shall be subject to review and audit by the Ministry, at the Ministry's own risk and expense, without prior notice, at any time during the retention period during regular business hours;
31. I/we agree that the Ministry or the health units do not guarantee supply of the vaccine, nor that the vaccine will be delivered in a timely manner. In particular, there may be unanticipated restrictions on the availability of vaccine and/or delays in vaccine delivery. I/we agree that the Ministry does not warrant or represent that the vaccine will be available at all times;
31. I/we will ensure that all persons who will be administering, transporting, handling and/or storing the influenza vaccine will be made aware of the all the requirements of this *Prequalification Form*;

I have read this page (INITIALS):



32. I/we understand that approval to participate in the seasonal UIIP is contingent on: 1) submission of a completed *Prequalification Form* and liability insurance to the Ministry AND 2) an approved cold chain inspection from the health unit. I/we understand that we will be notified via email if we have or have not met the requirements to participate in 2009-2010 seasonal UIIP season by October 1, 2009. If our organization is approved to participate in the UIIP we will also be given access to the seasonal UIIP implementation information package. This correspondence should be sent to:

Name of Contact (<i>First Name, Last Name</i>)	Email Address
Telephone Number ()	Facsimile Number ()

I/we understand that I/we are responsible for updating the Ministry via email at UIIP.MOH@ontario.ca if this information changes.

I agree, by my signature below, to comply with all the terms and conditions as set out in this Form. By signing this Form, I agree that I have authority to bind my Organization. I understand that failure to comply with the terms and conditions as set out in this Form by myself or by my organization may result in removal of me or my organization's access to publicly-funded vaccine, and removal from the Seasonal Universal Influenza Immunization Program (seasonal UIIP)

Signature	Date (<i>yyyy/mm/dd</i>)
Name (<i>please print</i>)	
First Name	Last Name
Position Title	Telephone Number ()

For Internal Use Only

Received by UIIP, Ministry of Health and Long-Term Care

Signature	Date (<i>yyyy/mm/dd</i>)
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Vaccine Refrigerator 3			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 5			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 7			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 9			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 11			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 13			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code

Vaccine Refrigerator 4			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 6			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 8			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 10			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 12			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code
Vaccine Refrigerator 14			
Name of Organization			
Name of Contact (<i>First name, Last name</i>)		Telephone ()	
Number	Street Name		
City		Province	Postal Code