

**Owner Name:   Jeremy Lancaster**

**Owner Phone Number:       724-263-3475**

**Owner Email:   jeremy@jeremylancasterconsulting.com**

**Drop Off Date: 2013-11-18**

**Pick Up Date:   2013-11-22**

**Number of Dogs:         3**

**Board them together:   1**

**Dog Name(s):   Sophie**

**Dog Age(s):       1**

**Dog Breed(s):   German Sheperd**

**List of Allergies:         None**

**List Of Medications       None**

**Flea Medication:         None**

**Feeding Requirements:     Nothing Special**

**Treats               1**

**Walks               1**

**Dog Park           1**

**Play Time          1**

**Report Card**

# Vaccine Upload

## 2010 IMMUNIZATION PROVIDER VACCINE AGREEMENT

between

State of Maine \* Maine Centers for Disease Control \* Maine Immunization Program  
286 Water Street, Key Plaza, 9<sup>th</sup> Floor, 11 State House Station  
Augusta, Maine 04333-0011  
Phone (207) 287-3746, 1-800-867-4775 \* Fax (207) 287-8127, 1-800-437-5743

and

Pin # \_\_\_\_\_ Practice: \_\_\_\_\_

Organization: \_\_\_\_\_

Vaccine Manager: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

Medicaid Provider #: \_\_\_\_\_ Federal Tax ID #: \_\_\_\_\_

### Vaccine Delivery Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Mailing Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(NOTE: Please make corrections to above information and fill in blank fields)

Please indicate any day(s) the Office is **Closed**: \_\_\_\_ Mon \_\_\_\_ Tues \_\_\_\_ Wed \_\_\_\_ Th \_\_\_\_ Fri

### Type of Facility (please check only one box):

- ☐ A. Public Health Department - 10 (A state, district, county or city public health clinic)
- ☐ B. Federally Qualified Health Center (FQHC) - 15 (Primary care clinics funded by the Bureau of Primary Health Care (BPHC/HRSA) as well as FQHCs and "look-alikes" not funded by BPHC)
- ☐ C. Rural Health Clinic (RHC) - 15 (A clinic located in a shortage area as designated by HCFA)
- ☐ D. Other Public Health - 16 (Any other public funded clinic which provides immunizations, for example Indian Health Service/Tribal Health Clinic, public school or state, district, county, city public outpatient clinic)  
Please designate: \_\_\_\_\_
- ☐ E. Private Practice (Individual or Group) - 20
- ☐ F. Private Hospital - 22
- ☐ G. Other Private Facility - 24 (For example, Nursing Homes, Long Term Care, Manufacturers)

### Age Cohort Summary (please check only one box):

- ☐ 0-18 years ☐ 19-99+ years ☐ 0-99+ years

The information contained in this agreement should be kept up to date throughout 2010. Please notify the Maine Immunization Program at 287-3746, within 10 days of a change of information, to update the contents of this agreement.