



# Vaccine Clinic Request Form

Organization Name

Organization Address

Person of contact: Name

Phone number

Email address

Clinic location (Name AND Address)

Preferred Days AND Times \*clinic not to exceed 2 hours\* (Mon-Sat: 7AM-8PM, at least 2 weeks' notice)

If you are requesting a clinic longer than 2 hours, please provide additional justification below:

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Estimated # of Participants (for worksites: please submit a completed sign-up sheet 3 days prior to requested clinic date) \_\_\_\_\_

If this clinic will be part of a community event, please provide additional details below:

Name and location	
Date and Time	
Name of organizer	

Please check yes or no for the following questions:

Will the clinic be hosted indoors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
If outdoors, will a canopy/shade tent be provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Will garbage cans be provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Will we have access to electricity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Will tables be provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Will chairs for staff be provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Will chairs for an observational area be provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
If located at a worksite, does your worksite have access to onsite services? (Clinic, pharmacy, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Please provide a brief description of your population. Do they fit into any of these categories?

<input type="checkbox"/> Individuals primarily over the age of 65	<input type="checkbox"/> Uninsured Individuals	<input type="checkbox"/> Homeless	<input type="checkbox"/> Language Barriers
<input type="checkbox"/> Disabled	<input type="checkbox"/> Transportation Barriers	<input type="checkbox"/> Low Income / Individuals who work multiple Jobs	<input type="checkbox"/> Located in a rural community

Please include any additional information

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**Type of vaccine requested**

<input type="checkbox"/> COVID	<input type="checkbox"/> FLU
*If requesting COVID, what type of dose is needed?	
<input type="checkbox"/> Primary Series	<input type="checkbox"/> Booster

\*\*If requesting first dose, would you like to schedule a follow up clinic 28 days later? (please provide the date, time, and location

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**\*\*For Weber-Morgan Health Department Staff Only\*\***

Has the form been graded according to the rubric?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did the form receive a passing score?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Signature of grader:		Date
Signature of leadership:		Date
Has the requester been notified of request status?	<input type="checkbox"/> Yes	<input type="checkbox"/> No