Maine Immunization Program – Vaccines for Adults
Provider Profile Form

All healthcare providers participating in the Maine Immunization Program – Vaccines for Adults Program must complete this form annually or more frequently if the number of eligible adults served changes or the status of the facility changes during the calendar year.

Date: ___ ___ /___ ___/ ___ ___ ___ ___ **Provider Identification Number#_____**

FACILITY INFORMATION		
Provider's Name:		
Facility Name:		
Vaccine Delivery Address:		
City:	**State:**	**Zip:**
Telephone:	**Email:**	

FACILITY TYPE (select facility type)

☐ **Private Facilities**	☐ **Public Facilities**	
☐ Private Hospital	☐ Public Health Department Clinic	☐ Woman Infants and Children
☐ Private Practice (solo/group/HMO)	☐ Public Hospital	☐ STD/HIV
☐ Community Health Center	☐ FQHC/RHC (Community/Migrant/Rural)	☐ Family Planning
☐ Pharmacy	☐ FQHC Look-Alikes	☐ Correctional Facility
☐ Other_____	☐ Tribal Health Centers	☐ Drug Treatment Facility
	☐ Indian Health Services (IHS) Centers	☐ Migrant Health Facility
	☐ Community Health Center	☐ Refugee Health Facility
	☐ Tribal/Indian Health Services Clinic (Urban)	
	☐ Other_____	

PATIENT POPULATION ESTIMATES

Estimated Number of Patients that are 19+ and uninsured/underinsured: _____

VACCINES OFFERED (select only one box)

☐ All ACIP-Recommended Vaccines.
☐ Offers Select Vaccines

Select Vaccines Offered:

○ DTaP	○ Meningococcal Conjugate	○ Td/Tdap
○ Hepatitis A	○ MMR	○ COVID-19
○ Hepatitis B	○ Pneumococcal Conjugate	○ Varicella
○ HIB	○ Pneumococcal Polysaccharide	○ Zoster Recombinant
○ HPV	○ Polio	○ Other, specify:
○ Influenza	○ RSV	