Health New Zealand
Te Whatu Ora

Application for Initial Approval as an Authorised Vaccinator (District)

Name:		Registration number:	
Workplace name and address:			
Work telephone:		Home telephone:	
Home address:			
Work e-mail:		Personal E-mail:	
Occupation Group:	☐ Practice Nurse ☐ Public Health Nurse ☐ Nurse Practitioner	☐ Māori or Pacific Health Nurse ☐ Occupational Health Nurse	☐ Secondary Care Nurse: Area of Specialty: _____ ☐ Other: Specify: _____

To be completed by the applicant - required documentation

I enclose the following required documentation:

☐ Copy of Certificate of Completion of Vaccinator Training Course (and any updates undertaken since then if applicable)

☐ Copy of current New Zealand Annual Practising Certificate from NZ Nursing Council website

☐ Copy of current CPR Certificate – Resuscitation requirements as per Appendix 4, Table A4.2 in the online current Immunisation Handbook 2020

☐ Indemnity Insurance is recommended

Declaration

I wish to apply to the medical officer of health for approval as an authorised vaccinator as per Appendix 4 of the current Immunisation Handbook

I declare that the above is true and correct information

Applicant signature: Date:

To be completed by immunisation coordinator

Clinical assessment completed by: Designation: Date:	☐ Full (i.e. adults, children & babies) or ☐ Deltoid only (for which the vaccinator has appropriate competencies)

Authorisation valid for 2 years from the date of initial VTC or most recent 4-hour IMAC update:	Your authorisation covers: a) All Funded vaccines on the current NZ Immunisation Schedule b) Influenza vaccines for the Well Population (unfunded) c) Vaccines on a 'Local Immunisation Programme'

Please Allow Up To 4 Weeks for Processing of Your Application

Forward Application to: **Immunisation Administrator** Public Health South Private Bag 1921 **Dunedin 9054** **E-mail:** **vpdimmunisation@southerndhb.govt.nz**	Office Use: All documents enclosed: ☐ Yes ☐ No☐ Approved To : ____/____/____ ☐ Declined	**Checked by Immunisation Coordinator:** **Signature: (only if required)** _____

Approved by Medical Officer of Health:
Signature: **Date:**