Application for Renewal of Approval as an Authorised Vaccinator (District)

Health New Zealand
Te Whatu Ora

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 Attendance at a Vaccinator Update

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

☐ I Declare that I hold a current CPR Certificate – Resuscitation requirements as per Appendix 4, Table A4.2 in the online Current Immunisation Handbook 2020

☐ Indemnity Insurance is recommended ☐ Peer assessment (only if required by immunisation coordinator)

Declaration

I wish to apply to the medical officer of health for renewal of approval as an authorised vaccinator as per Appendix 4 of the current Immunisation handbook.
My previous authorisation expires on: _____/_____/_____

I am able to provide a summary of my immunisation practice in the past 2 years if requested.

I declare that the above is true and correct information

Authorisation is valid for 2 years from the last IMAC 4 hour update	Your authorisation covers: a) Vaccines on the current NZ Immunisation Schedule b) Influenza vaccines for the Well Population (unfunded) c) Vaccines on a 'Local Immunisation Programme'	☐ Full (i.e. adults, children & babies) or ☐ Deltoid only (for which the vaccinator has appropriate competencies)

Applicant signature: Date:

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: **Date:**

Signature: