PROVIDER WITHDRAWAL FORM

*PIN:________________________ *Withdrawal Date:________________________

Please complete this form when you no longer wish to participate in the Texas Vaccine for Children (TVFC) Program. Fax the completed form to your Regional TVFC contact. Any remaining state vaccine will be picked up within 5 days of withdrawal from the TVFC Program. Please remember that Texas Health Steps providers may not refer Texas Health Steps patients elsewhere for immunizations.

Name of Facility: ____

Provider Name: ____
(Last Name) (First Name) (MI) (Title)

Contact Name: ____
(Last Name) (First Name) (MI) (Title)

Address: ____
(Street Address) (City) (Zip) (County)

Phone #: (______)________-_____________ Fax #: (______)________-_____________

***Reason for Withdrawal:**

- ☐ 1. Facility is Closing
- ☐ 2. No Longer Seeing Children
- ☐ 3. Too Much Paperwork
- ☐ 4. Staffing Issues
- ☐ 5. Physician no longer practicing
- ☐ 6. Not Using TVFC Vaccine
- ☐ 7. No Longer Enrolled in Medicaid
- ☐ 8. Relocating Out of Area
  *New County ______________________________
  New Address ______________________________
  ____
- ☐ 9. Other: ______________________________
  ____

*Required Fields

For HSR/LHD Use Only:

Date faxed to HSR: ___/___/___

Date faxed to AO: ___/___/___

Date vaccines picked up: ___/___/___

TEXAS Department of State Health Services

Texas Department of State Health Services
Immunization Branch

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