Regional Public Health
HAUORA Ā IWI KI TE ŪPOKO O TE IKA A MĀUI
Better health for the greater Wellington region

# Authorised Vaccinator - Greater Wellington Region

***Please send completed application to: Vaccinator Authorisation, Regional Public Health, Private Bag 31 907, Lower Hutt 5040***
***Or Email to: rph@huttvalleydhb.org.nz Attention: Vaccinator Authorisation***

| **Applicant Details** | |
|---|---|
| **Name:** | |
| **Address:** | |
| **Contact Phone:** | **Email:** |
| **Organisation:** | **Position Held:** |
| **Work Phone:** | **PHO:** |

| **Application for** | | |
|---|---|---|
| ❑ Initial Authorisation | ❑ Re-Authorisation | ❑ Authorised Vaccinator transferring into the region |

| **Authorisation to cover** | |
|---|---|
| ❑ National Schedule Vaccinations | ❑ Influenza vaccination only |
| ❑ Non-Scheduled Vaccinations (only with a current LIP) | *Note: Travel vaccines are not included in Local Immunisation Programmes* |
| Name/s of Local Immunisation Programme/s that you will be working under: | |
| | |

| **Documentation required** | |
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| **All applications to include copies of:** | |
| ❑ | Current APC Certificate *(both sides)* |
| ❑ | Current CPR qualification *(ensure this meets the required standard for Authorised Vaccinators)* |
| **If you are applying for Initial Authorisation, please include:** | |
| ❑ | Certificate of Attendance at a Vaccinator Training Course |
| ❑ | Clinical Competency Assessment *completed by DHB Immunisation Coordinator* |
| **If you are applying for Re-Authorisation, please include:** | |
| ❑ | Certificate of specific IMAC education update for trained vaccinators *minimum 4 hours* |
| ❑ | Summary of your immunisation practice over preceding 12 months *see below* |
| ❑ | Peer Review Assessment by authorised vaccinator *optional unless lapsed for >6 months* |
| **If you are applying as a Vaccinator transferring to this region, please include:** | |
| ❑ | Current Authorisation in another area |
| ❑ | Details of proposed work in the Greater Wellington Region |

| **Summary of Immunisation Practice** *(please do not send copies of individual vaccines given)* |
|---|
| I work in the following settings: ❑ Primary Care ❑ Occupational Health ❑ Schools ❑Other (specify):_____ |
| I have administered vaccines to children (0 – 5 years) in the last two years. ❑ Yes ❑ No |
| I have administered vaccines to adults and children (5 years and over) in the last two years. ❑ Yes ❑ No |
| I have given approximately _____ vaccines in the last two years. |

| |
|---|
| I have given the following vaccinations: ❑ Intramuscular ❑ Subcutaneous ❑ Intradermal ❑Other (specify):_____ |
| Other Responsibilities (designated coldchain person, etc): |

**NB**. If you have not administered childhood vaccines to children under 5 years, your authorisation will be for adults and children over 5 years only.

| **Declaration** | | |
|---|---|---|
| **I have a current CPR qualification** which meets the Medical Officer of Health's requirements for Authorised Vaccinators. See section A4.2, page 637, Immunisation Handbook 2017. | ❑ Yes ❑ No | |
| I am competent and meet the Immunisation Standards for Vaccinators as per Appendix 3, pages 615-627, Immunisation Handbook 2017. | ❑ Yes ❑ No | |
| I am aware that it is recommended that as a Vaccinator **I carry indemnity insurance** for personal/professional protection. | ❑ Yes ❑ No | |
| I declare that all of the information I have provided is true and accurate at the time of application. | ❑ Yes ❑ No | |
| **Signature:** | **Date:** | |

❑ I prefer to receive my authorisation letter by email only

| ***Office Use Only*** | |
|---|---|
| **Accreditation Recommendation** ***Immunisation Coordinator to complete*** ***[Initial Authorisation Only]*** | |
| Accreditation recommendation for: *(name)* _____ by Immunisation Coordinator for Initial Authority. | ❑ Yes ❑ No |
| ❑ Adult Only Vaccinator ❑ Child & Adult Vaccinator ❑Other (specify):_____ | |
| **Signature:** | **Date:** |