

Application for Renewal of 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:	<input type="checkbox"/> Practice Nurse <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Māori or Pacific Health Nurse <input type="checkbox"/> Occupational Health Nurse	<input type="checkbox"/> Secondary Care Nurse: Area of Specialty: _____ <input type="checkbox"/> Other: Specify: _____
To be completed by the applicant - required documentation			
I enclose the following required documentation: <input type="checkbox"/> Copy of Certificate of Attendance at a Vaccinator Update <input type="checkbox"/> Copy of current New Zealand Annual Practising Certificate from NZ Nursing Council website <input type="checkbox"/> 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 <input type="checkbox"/> Indemnity Insurance is recommended <input type="checkbox"/> 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' <input type="checkbox"/> Full (i.e. adults, children & babies) or <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Approved to ____/____/____ <input type="checkbox"/> Declined		Checked by Immunisation Coordinator: Signature: (only if required) _____
Approved by Medical Officer of Health: Signature:		Date:	