

## 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:	<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:

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 On-line 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:	<input type="checkbox"/> Full (i.e. adults, children & babies) or <input type="checkbox"/> Deltoid Only (for which the vaccinator has appropriate competencies)
Designation: _____ Date: _____	

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'
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## Please Allow Up To 4 Weeks for Processing of Your Application

<b>FORWARD APPLICATION TO:</b> <b>Immunisation Administrator</b> Public Health South Private Bag 1921 <b>DUNEDIN 9054</b> <b>Email:</b> <b>AuthVaccinator@southernhdb.govt.nz</b>	Office Use: All documents enclosed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Approved To : ____/____/____ <input type="checkbox"/> Declined	<b>Checked by Immunisation Coordinator:</b> <b>Signature: (Only if required)</b> _____
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Approved by Medical Officer of Health: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_