

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

Name		Registration Number	
Workplace Name And Address			
Work Telephone		Home Telephone	
Home Address			
Work Email		Personal Email	
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 On-line 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 up-date	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 <u>Email:</u> AuthVaccinator@southerndhb.govt.nz	Office Use: All Documents Enclosed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Approved to ____/____/____ <input type="checkbox"/> Declined	Checked by Immunisation Coordinator: Signature: (Only if required) <hr style="border: 1px solid black;"/>	
Approved by Medical Officer of Health: Signature:		Date:	