



**Authorized Private Provider User Agreement  
For Access to Florida SHOTS  
(Florida State Health Online Tracking System)**



**Florida SHOTS is...**

a centralized database for recording and tracking childhood immunizations as authorized by s. 381.003, F.S.

- Completion of this agreement according to the following conditions and instructions is required for authorized access to Florida Shots.

**AGREEMENT AND UNDERSTANDING**

**PLEASE READ CAREFULLY. As a CONDITION for enrolling in the Florida State Health Online Tracking System, AUTHORIZED USERS AGREE TO:**

1. Use the database to register and record immunization information for children currently receiving vaccinations under their care.
2. Comply with parent or legal guardian's request not to participate in Florida SHOTS by providing DH Form 1478, Florida SHOTS Notification and Opt Out Form to parents, or referring parents to the Department of Health Bureau of Immunization.
3. Allow parents to review information in their child's immunization record and correct data errors.
4. Notify Florida SHOTS personnel immediately in the event of medical license suspension or revocation.
5. Enter accurate current and historical vaccination data in Florida SHOTS at the time of vaccine administration.
6. Accept and abide by all relevant state statutes concerning medical record confidentiality and Florida SHOTS access.
7. Ensure that facility staff accessing Florida SHOTS using the health care provider user name and password adhere to all laws and regulations pertaining to use and access.
8. Contact Florida SHOTS to request new user IDs and passwords when necessary to prevent breaches of confidentiality.
9. Safeguard user IDs and passwords against unauthorized use and assume responsibility for staff access to Florida SHOTS using the licensed provider's authorization.

**In addition, for all authorized users of Florida SHOTS, it is UNDERSTOOD that:**

1. Authorized licensed providers may assign staff access to Florida SHOTS and are solely responsible for managing such access.
2. Any authorized user can view the immunization information in the system for any patient in the system who is under their care, but can only modify vaccination information they provided.
3. The provider agrees to be solely liable and hold the Department of Health harmless for any breaches of confidentiality by the provider, or the provider's employees or agents.

**Complete and submit the form on the reverse side according to the following instructions:**

**INSTRUCTIONS:**

**SECTION I – Licensed Health Care Provider Information**

1. Provide the name of health care providers licensed under Chapters 458, 459 or 464, F.S., and current medical license number. Only health care providers licensed under the statutes above may be issued user IDs and passwords for immunization registry use.
2. Provide a contact name and telephone number in the event that Florida SHOTS personnel have questions regarding this agreement.

**SECTION II – Provider Practice Facility Information**

Fill out all spaces for each facility where the licensed provider practices and requests access to Florida SHOTS. Access at each facility will be through the providers same user ID and password.

**SECTION III – Agreement Submission**

- Mail or fax this form to the address or fax number indicated. If you have any questions regarding completion of the form or about Florida SHOTS, please call the phone number provided.



**Authorized Private Provider User Agreement  
For Access to Florida SHOTS  
(Florida State Health Online Tracking System)**



**Section I - Licensed Health Care Provider (licensed under Chapters 458, 459 or 464, F.S.)**

✓ Upon approval of this agreement, providers will be issued user identification and passwords for access to Florida SHOTS. Providers may then allow their individual staff who are authorized or approved following standard internal security procedures such as background checks conducted by the facility to access Florida SHOTS using the provider's authorization. **Providers are responsible for contributing to the immunization registry through data entry or electronic data transfer, ensuring staff adherence to confidentiality, managing staff turnover that requires system access termination, and managing new staff access through appointing an administrator at the site. Access to Florida SHOTS may be terminated for non-use or for failure to adhere to this agreement.**

**Agreement - By signing below, I agree to abide by all terms of this agreement.**

Licensed Provider Name: \_\_\_\_\_ License #: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Vaccines for Children PIN# (if applicable) \_\_\_\_\_  
 Electronic Medical Records provider: \_\_\_\_\_  
**Contact Name for this application:** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
 E-Mail Address: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
 Title: \_\_\_\_\_

**Section II - Provider Practice Facility Information**

Please list information for your clinic location(s) below. If your organization has more than two sites, additional sheets may be attached as necessary.

Organization Name (if applying as a group): \_\_\_\_\_

Name of Facility: \_\_\_\_\_  
 Type of Facility: CMS, CHC, CHD,  
 Doctor's Clinic,  Public School Clinic,  
 Non-Public School Clinic,  Hospital Clinic  
 Hospital ER,  Military Medical Facility,  
 Other: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip: \_\_\_\_\_ County: \_\_\_\_\_  
 Phone:(\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
 Site contact name: \_\_\_\_\_

Name of Facility: \_\_\_\_\_  
 Type of Facility: CMS, CHC, CHD,  
 Doctor's Clinic,  Public School Clinic,  
 Non-Public School Clinic,  Hospital Clinic  
 Hospital ER,  Military Medical Facility,  
 Other: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip: \_\_\_\_\_ County: \_\_\_\_\_  
 Phone:(\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
 Site contact name: \_\_\_\_\_

**SECTION III - Agreement Submission**

Please keep a copy for your files and mail or fax this side of the agreement to:

Florida Department of Health  
 Bureau of Immunization  
 4052 Bald Cypress Way  
 Bin # A11  
 Tallahassee, Florida 32399-1719

Telephone: 877-888-SHOT (7468)  
 Fax: (850) 412-5801