



APPLICATION FOR INITIAL APPROVAL AS AN AUTHORISED VACCINATOR

CONTACT DETAILS – ALL FIELDS IN THIS SECTION ARE REQUIRED			
Name			Registration #
Workplace Name			
Workplace Address			
Workplace Phone		Home Phone / Mobile	
Home Address			
Email Address			
Occupation Group:	<input type="checkbox"/> Practice Nurse <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Māori Health Nurse <input type="checkbox"/> Pacific Health Nurse	<input type="checkbox"/> Occupational Health Nurse <input type="checkbox"/> Other, specify:	
REQUIRED DOCUMENTATION			
I enclose the following documentation:			
<input type="checkbox"/> Copy of Certificate of Completion of Vaccinator Training course (and any updates completed since then, if applicable) <input type="checkbox"/> Copy of current CPR Certificate <input type="checkbox"/> Copy of Clinical Assessment completed by Immunisation Coordinator <input type="checkbox"/> Copy of current New Zealand Annual Practising Certificate (both sides) <input type="checkbox"/> Evidence of Indemnity Insurance (recommended)			
DECLARATION			
I wish to apply to the Medical Officer of Health for approval as an Authorised Vaccinator.			
All of the above is true and correct information.			
APPLICANT SIGNATURE:		DATE:	
TO BE COMPLETED BY IMMUNISATION COORDINATOR			
Clinical Assessment completed by:		Contact Phone Number:	
Applicant clinically competent to vaccinate (as per assessment of clinical practice for vaccinators):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full (i.e. includes vastus lateralis) or <input type="checkbox"/> Deltoid only	
SIGNED:		DATE:	
Please scan in all documents and email to: vaccinator@cdhb.health.nz		Dr Ramon Pink Medical Officer of Health Community and Public Health PO Box 1475 CHRISTCHURCH 8140	
PLEASE ALLOW UP TO 4 WEEKS FOR YOUR APPLICATION TO BE PROCESSED			