



Immunization Program

VFC Eligibility Tracking Form for Birthing Hospitals

Hospital Name: _____

VFC #: _____

Accountability Period		Date of Hep B Vaccine Administration (mo / day)	VFC Eligibility Category			
From: _____ / _____ / _____	To: _____ / _____ / _____		MEDICAID	NO INSURANCE	AMER. INDIAN or ALASKA NATIVE	INSURED
Patient Name	Date of Birth					
1		/				
2		/				
3		/				
4		/				
5		/				
6		/				
7		/				
8		/				
9		/				
10		/				
11		/				
12		/				
13		/				
14		/				
15		/				
16		/				
17		/				
18		/				
19		/				
20		/				

Totals:

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Provider Signature: _____

Date: _____