**Instructions**: To request redistribution or transfer of COVID-19 vaccine inventory from a location with an approved redistribution agreement (not required for a transfer) on file to a location within their organization (Redistribution) or outside their organization (Transfer), the Sending Provider shall complete and submit this form to [CVMS-help@dhhs.nc.gov](mailto:CVMS-help@dhhs.nc.gov) **with a subject line of Redistribution / Transfer Request**. Redistribution and transfer requests for COVID-19 vaccines require NC DHHS Immunization Branch approval to ensure proper storage capabilities and tracking of COVID-19 vaccine inventory movements.

All COVID-19 vaccine providers must comply with the CDC requirements for vaccine management, including storage and handling, and temperature monitoring at all times. Providers must keep all records related to COVID-19 vaccine management for a minimum of 3 years, or longer if required by law. Please call 1-877-873-6247 if you have any questions.

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Request: |  | Name of Person Completing Form: |  |
| Reason for Request: |  | | |

**Sending COVID-19 Enrolled Provider Information**

|  |  |  |  |
| --- | --- | --- | --- |
| CVMS Location Name: |  | Provider Identification Number: |  |
| Street Address: |  | City: |  |
| Phone Number: |  | Zip: |  |
| Primary Vaccine Coordinator: |  | Primary Vaccine Coordinator Email: |  |

**Receiving COVID-19 Enrolled Provider Information**

|  |  |  |  |
| --- | --- | --- | --- |
| CVMS Location Name: |  | Provider Identification Number: |  |
| Street Address: |  | City: |  |
| Phone Number: |  | Zip: |  |
| Primary Vaccine Coordinator: |  | Primary Vaccine Coordinator Email: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **COVID-19 Vaccine(s) Being Redistributed or Transferred** | | | | | |
| Manufacturer Name | Vaccine Inventory Record Name (from CVMS) | Manufacturer Lot # | Expiration Date | # of Un-opened Vials | # of Doses |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Sending Provider shall check the boxes below to confirm they have adhered to the following requirements:**

|  |  |
| --- | --- |
|  | Sending Provider and Receiving Provider location names and Provider Information Numbers listed above match exactly how they appear in the COVID-19 Vaccine Management System (CVMS) Provider Enrollment Portal |
|  | Sending Provider has a completed CDC COVID-19 Vaccine Redistribution Agreement (not needed for Transfers) in the CVMS Provider Enrollment Portal and the Receiving Provider has a fully completed and submitted CDC COVID-19 Vaccine Program Provider Agreement and Profile in the CVMS Provider Enrollment Portal |
|  | Sending Provider has confirmed with Receiving Provider that they have the appropriate capability and capacity to store the COVID-19 vaccines |
|  | Sending Provider is not requesting redistribution or transfer of open or partial vials  Sending Provider is also shipping associated ancillary kit |
|  | Only COVID-19 vaccines are listed on this request |

**For NC DHHS Immunization Branch Use Only**

|  |  |  |  |
| --- | --- | --- | --- |
| Reviewed By: |  | Date Reviewed: |  |
| Approval Decision: |  | Comments: |  |