Pharmacy Outreach Immunization Worksheet for 2024-2025 Season

Instructions for Congregate Care Facility: You need to complete a separate worksheet for each Pharmacy Provider. Fill in Facility Information and send a copy to each of your Pharmacy Provider(s).

Facility Information	
Name of Facility	AHS Zone
Primary Contact	
Name & Role/Job Title	Fax
Email	Phone *(include extension if applicable)*
Vaccine Doses Required to Support This Facility	
Total # of High Dose Quadrivalent Influenza doses for 65 years and over	Total # of Standard Quadrivalent Influenza doses for 64 years and under
Total # of COVID-19 doses	

** When your Pharmacy Provider returns this form, keep a copy on hand to assist with the completion of the Provincial Partner Oversight (PPO) Outreach Immunization Survey.*

Instructions for Pharmacy: Complete the section below and return the form to the Congregate Care Facility.

Pharmacy Information		
Name of Pharmacy and Store # (e.g.Rexall 7220)	ACP ID number *(ACP ID:1234)*	
Address	City / Town	Postal Code
Phone *(include extension if applicable)*	Fax	
Name of Primary Wholesale Distributor (PWD)		
Primary Contact		
Name	Email	
Alternate Contact		
Name	Email	
Vaccine Doses to be Provided by Pharmacy		
Total # of High Dose Quadrivalent Influenza doses	Total # of Standard Quadrivalent Influenza doses	
Total # of COVID-19 doses		