Pharmacy Outreach Immunization Worksheet for 2023-2024 Season

Instructions for Congregate Care Facility: Complete first section (Facility Information) and send to 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		
# of High Dose Quadrivalent Influenza Doses for 65 years and over Residents Staff	# of Standard Quadrivalent Influenza Doses for 64 years and under Residents Staff	
# of COVID-19 Doses Overall Residents Staff		

** 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 section below and return to Congregate Care Facility.

Pharmacy Information		
Name of Pharmacy *(as it appears in the AVI system)*	License # / AB Provider ID *(AB0000XXXX)*	
Address	City / Town	Postal Code
Phone *(include extension if applicable)*	Fax	
Primary Wholesale Distributor	Wholesale Account #	
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		