Authorized Licensed Pharmacist

User Agreement

For Access to Florida SHOTS

(Florida State Health Online Tracking System)

Florida SHOTS is...

a centralized database for recording and tracking immunizations by s. 381.003, F.S

Completion of this agreement according to the following conditions and instructions is required for authorized access to Florida SHOTS.

TERMS OF AGREEMENT

PLEASE READ CAREFULLY. As a CONDITION for enrolling in the Florida State Health Online Tracking System, AUTHORIZED USERS AGREE TO:

1. Access Florida SHOTS to register and record immunization information for patients currently receiving vaccinations under their care.
2. Enter accurate and current data in Florida SHOTS at the time of vaccination.
3. Accept and abide by all relevant state statutes concerning medical record confidentiality and Florida SHOTS access.
4. Ensure that pharmacy staff accessing Florida SHOTS, as authorized by the applicant, adheres to all laws and regulations pertaining to use and access.
5. Safeguard user IDs and passwords against unauthorized use and assume responsibility for staff access to Florida SHOTS.
6. Maintain user accounts such that only current authorized users have access to Florida SHOTS and all terminated staff are appropriately removed from access.
7. Contact Florida SHOTS to request new user IDs and passwords when necessary to prevent breaches of confidentiality.
8. Notify Florida SHOTS personnel immediately upon suspension or revocation of license or registration.

In addition, for all authorized users of Florida SHOTS, it is UNDERSTOOD that:

1. Authorized administrators may assign staff access to Florida SHOTS and are solely responsible for managing such access.
2. Any authorized user can view the immunization information for any patient in the system, but can only modify vaccination information they provided
3. The authorized licensed pharmacist agrees to be solely liable and hold the Department of Health harmless for any breaches of confidentiality by the facility.
4. Access to Florida SHOTS will be terminated upon license revocation or suspension, for breaches of confidentiality or failure to adhere to any portion of this agreement.

Complete and submit the form on page two according to the following instructions:

SECTION I - Authorized responsible individual information

1. Provide the name of the licensed pharmacist under chapter 465,F.S, and current pharmacist license number.
2. The authorized responsible individual must sign and date the agreement in the space provided. By signing the agreement, the authorized individual agrees to ensure that all staff accessing Florida SHOTS under his or her authorization will adhere to the same laws and regulations pertaining to access and maintaining confidential information.
3. Provide telephone number, fax number and email.

SECTION II - Pharmacy Facility Information

1. Provide the Pharmacy facility name, pharmacy license number, address, city, state, zip, county, phone and fax number.

SECTION III - Agreement Submission

1. Mail or fax this form to the address or fax number indicated. If you have any questions regarding completion of the form or about Florida SHOTS, please call the phone number provided.

2. Agreements will expire every two years after activation. At that time, contact the Department of Health, Bureau of Communicable Diseases for renewal.

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Pharmacists (licensed under section 465.007, F.S.)

- ✓ **Pursuant to s. 465.189 (4), F.S., Pharmacists certified to provide influenza vaccinations to adults must report such vaccinations to the state immunization registry (Florida SHOTS). Upon approval of this agreement, authorized Pharmacists will be issued user identification and passwords for access to Florida SHOTS. Pharmacists may then allow their individual staff, who are authorized or approved following standard internal security procedures such as background checks conducted by the facility, to access Florida SHOTS using the pharmacist's authorization. Pharmacists are responsible for contributing to the immunization registry as required by statute, and must ensure staff adherence to confidentiality, manage staff turnover that requires system access termination, and managing new staff access through appointing an administrator at the site. Access to Florida SHOTS may be terminated for non-use or for failure to adhere to this agreement**.

Section I - Agreement by signing below, I agree to abide by all terms of this agreement.

Pharmacist's Name:_____ Pharmacist License #:_____

Signature:_____ Date:_____

Phone: _____ Fax:_____ Email:_____

Section II - Licensed Pharmacy (pursuant to s.465.003,F.S)

Facility Name:_____ Pharmacy License #:_____

Address:_____ City:_____ State:_____

Zip:_____ County:_____ Phone:_____ Fax:_____

Section III-Agreement Submission

Please keep a copy for your files and mail or fax this side of the agreement to:

Florida Department of Health
Bureau of Communicable Diseases
4052 Bald Cypress Way
Bin # A11
Tallahassee, Florida 32399-1719

Telephone: 877-888-SHOT (7468)
Fax: (850) 412-5801
Alternate Fax (850) 922-4195

Form DH-1997, 01/14