

Joe Lombardo
Governor

Laura Rich
Director



DEPARTMENT OF HUMAN SERVICES



NEVADA DIVISION of PUBLIC
and BEHAVIORAL HEALTH



Andrea R. Rivers,
MS
Administrator

Ihsan Azzam,
Ph.D., M.D.
Chief Medical
Officer

State of Nevada
NSIP-STATE OPIOID RESPONSE (SOR) PROGRAM
MAY 2026 – JUNE 2027
AGREEMENT TO PARTICIPATE (ATP)

FACILITY INFORMATION			
Facility Name:			Pin:
Facility Address:			
City:	County:	State:	Zip:
Telephone:		Fax:	
Shipping Address (if different than facility address):			
City:	County:	State:	Zip:
MEDICAL DIRECTOR OR EQUIVALENT			
<p><i>Instructions: The health care provider signing the agreement must be a practitioner authorized to administer vaccines under state law who will also be held accountable for compliance by the entire organization and its providers with the responsible conditions outlined in the provider enrollment agreement. For the purposes of this agreement, a vaccine is defined as SOR allowable vaccine on the list of vaccines offered, below. This program is focused on areas with high vaccine preventable disease and high overdose rates. Providers who participated previously in SOR are all in qualified regions, if you are new to the SOR NSIP Program, NSIP can verify your eligibility. The individual listed here must sign the provider agreement.</i></p>			
Last Name, First, MI:			Title:
Specialty:	License No:	Medicaid or NPI No:	

Email:		Employer ID (optional):
VACCINE COORDINATOR		
Primary Vaccine Coordinator Name:		
Telephone:	Email:	
Completed annual training (optional): • Yes <input type="radio"/> No	Type of training received (optional):	
Back-Up Vaccine Coordinator Name:		
Telephone:	Email:	
Completed annual training (optional): • Yes <input type="radio"/> No	Type of training received (optional):	

IMPORTANT - Days and times the clinic is open to accept delivery of vaccines; at minimum, must be open at least four (4) consecutive hours on a weekday <u>other than Monday</u>:			
Day of the Week	Time Office Open for Delivery	Closed for LUNCH from/to	Time Office Closes
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
Notify the Nevada State Immunization Program (in writing) of any changes, i.e., clinic closures or changes in hours of operation.			

To receive SOR funded vaccines at no cost I agree to the following conditions, on behalf of myself and all the practitioners, nurses, and others associated with the healthcare facility of which I am the medical director, practice administrator or equivalent:

Medical Director, practice administrator or equivalent (one who is authorized to prescribe vaccines under Nevada State Law) to initial all:

1. SOR-funded vaccine can only be administered to uninsured adults aged 19 years and older. Any children aged birth – 18 years that meet these criteria are eligible for the Vaccines for Children (VFC) Program and should not receive SOR-funded vaccine and should instead receive VFC vaccine.
 - a. Uninsured: An adult who has no health insurance coverage:
2. I will comply with the immunization schedules, dosages and contraindications that are established by the ACIP as of June 24, 2025 (per [Nevada ACIP BOH DPBH Technical Bulletin March 2026](#)) and included in the NSIP-SOR Program, unless:
 - a. In the provider's medical judgment, and in accordance with accepted medical practice, the provider deems such compliance to be medically inappropriate (NRS 392.439, 394.194, 432A.250); or
 - b. The particular requirements contradict state law, including laws pertaining to religious exemptions (NRS 392.437, 394.193, 432A.240).
3. I will maintain all records related to the SOR Program for a minimum of three (3) years and will make these records available to public health officials, including the Nevada Department of Human Services and/or the U.S. Department of Health and Human Services, upon request.
4. I will immunize all eligible individuals with State-funded vaccine at no charge to the patient for the vaccine.
5. For uninsured adults, the administration fee charged should not exceed the SOR vaccine administration fee of \$22.00 per vaccine dose administered.
6. I will not deny administration of a federal or state-supplied vaccine to an established patient because the individual is unable to pay the vaccine administration fee.
7. I will distribute the most current Vaccine Information Statement (VIS) each time a vaccine is administered and will maintain records which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS).
8. I will comply with the requirements for vaccine management and accountability, including:
 - a. Ordering vaccine and maintaining appropriate vaccine inventories;
 - b. Not storing vaccine in "dorm-style" refrigerators, combination refrigerator/freezer, or beverage style refrigerators at any time;
 - c. Storing vaccine under proper conditions at all times. Refrigerator and freezer vaccine storage units must be standalone units must meet Nevada State Immunization Program requirements;
 - d. Return all eligible, publicly supplied spoiled/expired vaccine to CDC's centralized distributor within six (6) months of spoilage/expiration.
9. I agree to use the continuous digital monitoring devices provided by the NSIP to monitor vaccine storage units containing federal- and/or state-supplied vaccines. The NSIP will provide one (1) VFC400 continuous monitoring device with capabilities of alarming for out-of-

range temperatures, provides current temperatures and minimum/maximum temperatures, low battery indicator, accuracy of +/- 1°F (0.5°C), has memory storage capacity of at least 4,000 readings, used in conjunction with a detachable biosafe glycol-encased probe and comes with current certificates of calibration accredited by an ILAC MRA signatory body or meets ISO/IEC 17025 international standards. I understand it is the clinic's responsibility to pay for the biennial recalibration of the data logger. If I cannot use the digital monitoring devices supplied by the NSIP, then I agree to use a NSIP-approved alternative. I agree to return all equipment supplied to my office through federal or state funds to the NSIP upon termination of this agreement.

10. I agree to purchase at least one (1) backup digital monitoring device (data logger) with a valid and current certificate of calibration accredited by an ILAC MRA signatory body or meets ISO/IEC 17025 international standards, capable of alarming (visually or audibly) for out-of-range temperatures, provides current temperatures and minimum/maximum temperatures, low battery indicator, accuracy of +/- 1°F (0.5°C), used in conjunction with a detachable biosafe glycol-encased probe and have it readily available to ensure that twice a day temperature assessment and recording can be performed in the event the NSIP-supplied data logger is no longer working or has been sent out for recalibration.
11. In the event the NSIP Program Manager, Vaccine Manager, Provider Quality Assurance Manager, and/or the Vaccine Storage & Handling Coordinator recommends to my Primary or Backup Vaccine Coordinator and/or myself, the Medical Director, that I purchase a stand-alone refrigerator and/or freezer unit as a result of reviewing long-term continuous temperature monitoring data, and the office does not purchase the recommended storage unit type, then I WILL BE HELD ACCOUNTABLE for replacing all State-funded vaccine (at private cost) that are spoiled or wasted as a result of temperature excursions in the non-recommended unit.
12. I will participate in NSIP program compliance site visits including unannounced Storage and Handling visits and other educational opportunities associated with VFC program requirements.
13. I will maintain clients' immunization records for a period specified by NRS 629.051 "Health care records; retention; disclosure to patients concerning destruction of records; exceptions; regulations. #1...Each provider of healthcare shall retain the healthcare records of his or her patients as part of his or her regularly maintained records for 5 years after.... their receipt or production. Health care records may be retained in written form or by microfilm or any other recognized for of size reduction including, without limitation, microfilm or any other recognized for of size reduction, including, without limitation, microfiche, computer disc, magnetic tape, and optical disc...Health care records may be created, authenticated and stored in a computer system which limits access to those records. #7: A provider of health care shall not destroy the healthcare records of a person who is less than 23 years of age on the date of the proposed destruction of records. The health care records of a person who has attained the age of 23 years may be destroyed in accordance with this section for those records which have been retained for at least 5 years or for any longer period provided by federal law. If requested, I will make such records available to the Nevada Department of Health & Human Services and/or the U.S. Department of Health & Human Services. I will make such records available to the health authority and/or their designee, if requested (per NAC 441A.750). This includes the collection of data for quality improvement assessments.
14. I will record all vaccines that our office administers into Nevada's immunization information system, NV WebIZ, unless the patient has chosen not to participate. In order for a patient to opt-out of NV WebIZ, a form must be completed and sent to the NV WebIZ Help Desk. Providers with an undue hardship (i.e., no internet access) can comply by completing a NV WebIZ paper

reporting form and mailing to the NV WebIZ Program. Please contact the NV WebIZ Help Desk to obtain this form. These requirements are in reference to Nevada Revised Statute (NRS) and corresponding Nevada Administrative Code (NAC) R094-09A. View these laws at:

- NRS: <http://www.leg.state.nv.us/NRS/NRS-439.html#NRS439Sec265>
- NAC: <http://leg.state.nv.us/NAC/NAC-439.html#NAC439Sec870>
- NV WebIZ: http://dpbh.nv.gov/Programs/WebIZ/WebIZ_-_Home/

If a patient opts out of having their information in NV WebIZ, I will ensure all doses are accounted for in my inventory.

15. I agree to have all staff who enter data into NV WebIZ receive the appropriate training prior to obtaining a username, password, entering data, or receiving vaccine (new enrollees). I also agree to have the Primary and Back-up VFC coordinators complete “Data Entry” and “Inventory management/Reconciliation” training prior to being able to order State vaccine. I understand my clinic cannot be enrolled in the State SOR program until these classes have been completed by these individuals.
16. I agree to purchase a standalone freezer-less refrigerator, and separate freezer if applicable, if I am enrolling in the State SOR Program for the first time or if I open a new office location. I understand that I cannot use a combination style refrigerator/freezer or “Dorm Style”, or beverage style refrigerator to store federally or state funded vaccine.
17. I agree to notify the Nevada State Immunization Program of all changes immediately as they occur including, but not limited to:
 - Change of shipping/ mailing address;
 - Change in vaccine shipping hours;
 - Change of Primary or Back-Up Vaccine Coordinators;
 - Change of telephone, fax number or contact e-mail;
 - Additions/deletions of physicians, PA’s and nurse practitioners to the provider site.
18. I will not move/transport publicly supplied vaccines unless I have prior approval from the Nevada State Immunization Program.
19. I (the facility) will be held financially responsible for the dose-for-dose replacement cost of any publicly supplied vaccines that are wasted through my failure or the failure of my staff to properly store, handle, account for, or rotate the vaccines. Furthermore, replacement doses must be administered only to eligible individuals.
20. I will not borrow State SOR-funded vaccine to administer to non-State SOR eligible patient(s) unless a rare, unplanned situation exists. In the event an unplanned situation occurs that requires borrowing of State SOR-funded vaccine to administer to a non-State SOR eligible patient, or vice-versa, then I will be required to complete the “NSIP Vaccine Borrowing Report” to document the borrowed and replaced doses. I will submit this form with monthly reports for the month in which the borrowing occurs.

By signing this form, I certify on behalf of myself and all immunization providers in this facility, that I have read and agree to the State SOR enrollment requirements listed above and understand that I am accountable for compliance with all requirements.

Printed Name: Medical Director or equivalent:

Medical License and (One who is authorized to prescribe vaccines under Nevada State Law) NPI #:

Signature: Medical Director or equivalent:

Date:

LIST EACH PRESCRIBING AUTHORITY

Bureau of Child, Family and Community Wellness

4150 Technology Way, Suite 210 • Carson City, NV 89706 • (775) 684-4200 • Fax (775) 687-7570 • dphh.nv.gov

ALL IN GOOD HEALTH.

All healthcare providers participating in the State Opioid Response program must complete this form annually or more frequently if the number of eligible adults served changes or the status of the facility changes during the calendar year.

Date: / / Provider Identification Number# _____

FACILITY INFORMATION		
Provider's Name:		
Facility Name:		
Vaccine Delivery Address:		
City:	State:	Zip:
Telephone:	Email:	
FACILITY TYPE (select facility type)		
<input type="checkbox"/> Private Facilities	<input type="checkbox"/> Public Facilities	
<input type="checkbox"/> Private Hospital <input type="checkbox"/> Private Practice (solo/group/HMO) <input type="checkbox"/> Community Health Center <input type="checkbox"/> Pharmacy <input type="checkbox"/> Other	<input type="checkbox"/> Public Health Department Clinic <input type="checkbox"/> Public Hospital <input type="checkbox"/> FQHC/RHC (Community/Migrant/Rural) <input type="checkbox"/> FQHC Look-Alikes <input type="checkbox"/> Tribal Health Centers <input type="checkbox"/> Indian Health Services (IHS) Centers <input type="checkbox"/> Community Health Center <input type="checkbox"/> Tribal/Indian Health Services Clinic (Urban) <input type="checkbox"/> Other	
<input type="checkbox"/> Woman Infants and Children <input type="checkbox"/> STD/HIV <input type="checkbox"/> Family Planning <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Drug Treatment Facility <input type="checkbox"/> Migrant Health Facility <input type="checkbox"/> Refugee Health Facility <input type="checkbox"/> Ryan White Clinic		
VACCINES OFFERED (select only one box)		

- Allowable
SOR Select Vaccines for
Uninsured Adults

- Select Vaccines Offered:

- | | | |
|--------------------------------------|---|------------|
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Meningococcal Conjugate | • Td/Tdap |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Pneumococcal Conjugate | • COVID-19 |
| <input type="checkbox"/> HPV | <input type="checkbox"/> Pneumococcal Polysaccharid | |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Jynneos (Mpox) | |