Entity Enrollment Form

PhilaVax

Department of Public Health
CITY OF PHILADELPHIA

November 2020 | **vaccines@phila.gov**

Type of Organization Represented:

☐ **Health System** ☐ **Private Clinic** ☐ **EMR Vendor** ☑ **Other:** Pharmacy

Name of Organization Fishtown Pharmacy		
Mailing Address 1802 Frankford Ave		
City Philadelphia	State PA	Zip Code 19125
Email Address fishtownpharmacy@gmail.com		
Phone Number 267-687-7562	Extension	Fax Number 267-687-7703

I, the undersigned, as a representative of the above named responsible entity, have read and agree to abide by the Phila-Vax Reponsible Entity Security and Confidentiality Agreement.

Entity Representative Name (Please print) Kris Hunsicker	Title Owner / Pharmacist In Charge
Signature 	Date 12-09-2020

Please fax this form to: (215) 238-6944

Or email to: PhilaVax@phila.gov

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PDPH USE ONLY

Date Received:

Approved?:

Entered by:

Clinic Code: