Vaccinator Authorization Form

Department of Public Health
CITY OF PHILADELPHIA

This form should be completed by the supervising physician to provide authorization for medical assistants, pharmacy technicians, students and select other professions to administer COVID-19 vaccine. **Please have the supervising physician fill out the authorizing clinical section and sign below each listed vaccinator.** When filling out license information please provide the following information:

- Physicians- state license number
- Pharmacists- state license number and injectables license number
- Nurses- state license number
- Vaccinators- license number or student ID if applicable

Completed forms and questions should be sent to **covidproviders@phila.gov**.

Authorizing Clinician Information

Name (first, last):		**Title:** ☐MD ☐DO ☐RPh. ☐NP
License Number and State:		**Phone Number:**
Organization:		
Address:		**City:**
State:	**Zipcode:**	**Email:**

To the Philadelphia Immunization Program: I _____(authorizer's name) hereby authorize the following staff at to administer COVID-19 vaccine under my supervision as of today's date _____

Vaccinator Information

Name (first, last):		**Title:**
License Number and State:		**Phone Number:**
Organization:		
Address:		**City:**
State:	**Zipcode:**	**Email:**

Authorizer's signature: _____

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Vaccinator Information

Name (first, last):		Title:
License Number and State:		Phone Number:
Organization:		
Address:		City:
State:	Zipcode:	Email:

Authorizer's signature: ______________________________

Vaccinator Information

Name (first, last):		Title:
License Number and State:		Phone Number:
Organization:		
Address:		City:
State:	Zipcode:	Email:

Authorizer's signature: ______________________________

Vaccinator Information

Name (first, last):		Title:
License Number and State:		Phone Number:
Organization:		
Address:		City:
State:	Zipcode:	Email:

Authorizer's signature: ______________________________