



OFFICE USE ONLY	
<input type="checkbox"/> Approved	Date
<input type="checkbox"/> Denied	

Uniform Stamp: Yellow Fever Vaccine Center

Name (last) (first) (middle initial)	CA Medical License Number (Physicians Only)
Employer Name (if not-self employed)	
Current Address	City ZIP code
Day Time Phone Number	Other Phone Number Fax
Email Address	

I would like to request that the following address be added as a designated Yellow Fever Vaccine Center

1	Designated Provider (last) (first)	Check one <input type="checkbox"/> MD, DO <input type="checkbox"/> Pharmacist <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> other _____	Company Name	
	Center Address	City	County	ZIP code
	Day Time Phone Number	Other Phone Number	Fax	
	Email Address	I will need an additional stamp at this address <input type="checkbox"/> YES <input type="checkbox"/> NO		

2	Designated Provider (last) (first)	Check one <input type="checkbox"/> MD, DO <input type="checkbox"/> Pharmacist <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> other _____	Company Name	
	Center Address	City	County	ZIP code
	Day Time Phone Number	Other Phone Number	Fax	
	Email Address	I will need an additional stamp at this address <input type="checkbox"/> YES <input type="checkbox"/> NO		

3	Designated Provider (last) (first)	Check one <input type="checkbox"/> MD, DO <input type="checkbox"/> Pharmacist <input type="checkbox"/> RN <input type="checkbox"/> NP <input type="checkbox"/> other _____	Company Name	
	Center Address	City	County	ZIP code
	Day Time Phone Number	Other Phone Number	Fax	
	Email Address	I will need an additional stamp at this address <input type="checkbox"/> YES <input type="checkbox"/> NO		

Physician Signature	Date
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You may attach additional sheets as needed