



Uniform Stamp: Request For Replacement

Name (last)		(first)	(middle initial)	CA Medical License Number (Physicians Only)	
Current Mailing Address			City	ZIP code	
Day Time Phone Number		Other Phone Number		Fax	
Email Address		Year original stamp was received:			

Reason for requesting new stamp (please check one)

Lost
 Damaged: Please return damaged stamp with the application

You may have your uniform stamp replaced only 2 times after the original or recertification date of the stamp

Signature of Applicant	Date
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OFFICE USE ONLY

Approved
 Denied

First or Second Stamp:	Date ordered	Date shipped
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Approval Signature	Date
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Impression of Stamp

	<p>Please Mail To:</p> <p>Yellow Fever Vaccine Program California Department of Public Health Immunization Branch 850 Marina Bay Pkwy., Bldg. P Richmond, CA 94804</p>
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