



Uniform Stamp Application

Name (last)	(first)	(middle initial)	Please check one	CA Medical License Number (Physicians Only)
			<input type="checkbox"/> New Applicant <input type="checkbox"/> Recertification	

Employer Name (if not-self employed)

Employer Address	City	State	ZIP code
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Mailing Address	City	County	ZIP code
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Home Address	City	ZIP code
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Office Phone Number	Other Phone Number	Fax
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Email Address

Please indicate the services that you expect to provide (check all that apply):

<input type="checkbox"/> Other travel vaccinations (i.e. typhoid, hepatitis)	<input type="checkbox"/> Malaria prophylaxis	<input type="checkbox"/> Advice only for malaria prevention
<input type="checkbox"/> Prevention of traveler’s diarrhea	<input type="checkbox"/> Counseling for travel risks	<input type="checkbox"/> Post-travel evaluation
<input type="checkbox"/> Full medical practice		

I agree to comply with all guidelines established by the State of California, Department of Public Health pertaining to the use of the State Uniform Stamp. I understand that the stamp remains the property of the State of California, Department of Public Health and is subject to recall at the discretion of the Department.

Signature of Applicant	Date
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OFFICE USE ONLY

<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
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Date Received	Date Stamped
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Impression of Stamp	Please Mail To:
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	<p>Yellow Fever Vaccine Program</p> <p>California Department of Public Health Immunization Branch 850 Marina Bay Pkwy., Bldg. P Richmond, CA 94804</p>
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