



Idaho Immunization Program

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

Uniform Stamp: Designation of Yellow Fever Vaccine Center			
Name: (last)		(first)	(middle initial)
			Idaho Medical License Number (Physicians Only)
Employer Name (if not self-employed)			
Current Address		City	Zip code
Day Time Phone Number		Fax Number	Email Address
Email Address			
<i>I would like to request that the following address be added as a designated Yellow Fever Vaccine Center</i>			
1	Designated Provider (last)		(first)
			Check one <input type="checkbox"/> RN <input type="checkbox"/> MD, DO <input type="checkbox"/> NP/PA <input type="checkbox"/> Pharmacist <input type="checkbox"/> Other
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"/> RN <input type="checkbox"/> MD, DO <input type="checkbox"/> NP/PA <input type="checkbox"/> Pharmacist <input type="checkbox"/> Other
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"/> RN <input type="checkbox"/> MD, DO <input type="checkbox"/> NP/PA <input type="checkbox"/> Pharmacist <input type="checkbox"/> Other
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

