



OFFICE USE ONLY	Approved
	Denied

Designation of Yellow Fever Vaccine Center

Name (Provider of Record) Last		First	MI	Professional License Number	License Expiry Date
Provider of Record Address		City	County		Zip Code
Office Phone Number	Other Phone Number	Fax	Email Address		

Additional facility to be added as a designated Yellow Fever Vaccine Center

Additional stamp needed at this facility: **Yes** **No**

Name of Facility					
Designated Provider - Last		First	MI	Title (MD, DO, PharmD, RN, NP, etc.)	
Address		City	County		Zip Code
Office Phone Number	Other Phone Number	Fax	Email Address		

Additional stamp needed at this facility: **Yes** **No**

Name of Facility					
Designated Provider - Last		First	MI	Title (MD, DO, PharmD, RN, NP, etc.)	
Address		City	County		Zip Code
Office Phone Number	Other Phone Number	Fax	Email Address		

Additional stamp needed at this facility: **Yes** **No**

Name of Facility					
Designated Provider - Last		First	MI	Title (MD, DO, PharmD, RN, NP, etc.)	
Address		City	County		Zip Code
Office Phone Number	Other Phone Number	Fax	Email Address		

Applicant Signature			Date
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You may attach additional sheets as needed.