CDPH California Department of Public Health

OFFICE USE ONLY	☐ Approved ☐ Denied

UNIFORM STAMP APPLICATION

Applicant (Provider of Record) Last Name	First	MI	Professional License Number	License Expiry Date

Name of Practice

Address where vaccines are given	City	County	Zip Code

Office Phone Number	Other Phone Number	Fax	Email Address (for internal use, not for public listing)

☐ Advice Only for malaria prevention
☐ Counseling for travel risks
☐ Full medical practice
☐ Malaria prophylaxis
☐ Post-travel evaluation
☐ Prevention of traveler's diarrhea
☐ Other travel vaccine (i.e., typhoid, hepatitis)

Additional Provider(s)/Designee(s) at this facility (For additional facilities, use Designation Form)

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

Designated Provider - Last Name	First	MI	Title (MD, DO. PharmD, RN, NP)

Office Phone Number	Other Phone Number	Fax	Email Address

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

Designated Provider - Last Name	First	MI	Title (MD, DO. PharmD, RN, NP)

Office Phone Number	Other Phone Number	Fax	Email Address

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

Designated Provider - Last Name	First	MI	Title (MD, DO. PharmD, RN, NP)

Office Phone Number	Other Phone Number	Fax	Email Address

I agree to comply with all guidelines 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.

Applicant Signature	Date

You may attach additional sheets as needed.