OFFICE USE ONLY	Approved
	Denied

UNIFORM STAMP APPLICATION

Name (Physician of Record) Last		First	MI	CA Med. Lic. # (Physician Only)	Med. Lic. Expiry Date
Employer Name (if not self-employed)					
Employer Address (home address if self-employed)		City	County		Zip Code
Office Phone Number	Other Phone Number	Fax	Email Address		

Advice Only for malaria prevention | Malaria prophylaxis | Other travel vaccine (i.e., typhoid, hepatitis)

Counseling for travel risks | Post-travel evaluation

Full medical practice | Prevention of traveler's diarrhea

Additional Provider(s)/Designee(s) at this facility

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

Designated Provider - Last		First	MI	Title (MD, DO. RN, NP, etc.)
Office Phone Number	Other Phone Number	Fax	Email Address	

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

Designated Provider - Last		First	MI	Title (MD, DO. RN, NP, etc.)
Office Phone Number	Other Phone Number	Fax	Email Address	

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

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