OFFICE USE ONLY	☐ Approved ☐ Denied

Designation of Yellow Fever Vaccine Center

Name (Physician of Record) Last		First	MI	CA Med. Lic. # (Physician Only)	Med. Lic. Expiry Date
Physician 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. RN, NP, etc.)
Address		City	County	
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. RN, NP, etc.)
Address		City	County	
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. RN, NP, etc.)
Address		City	County	
Office Phone Number	Other Phone Number	Fax	Email Address	

Applicant Signature	Date

You may attach additional sheets as needed.