**DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
F-00375 (02/10)

**STATE OF WISCONSIN**

# YELLOW FEVER UNIFORM STAMP APPLICATION

(Complete a separate application for each site)

Physician Name _____ _____ _____
Last First MI

Title _____

WI State License _____ DEA _____

Phone (  ) _____ Fax (  ) _____

E-mail Address _____

**Location Where Vaccine Will be Administered**

Facility Name _____

Address _____

_____

City _____ Zip _____

Telepone (  ) _____ Fax (  ) _____

Web Site _____

Does your facility use the Wisconsin Immunization Registry (WIR) or RECIN? Yes ☐ No ☐

**Type of Facility** (check only one)

____ City health department
____ County/regional health department
____ Federal or military facility
____ Open to the public - not city, county or state health department
____ Private employer
____ University - only serves students & employees
____ Other

Is the physicians mailing address the same as the facility address listed above? Yes ☐ No ☐
If not, enter physicians mailing address

Address _____

_____

City _____ State _____ Zip_____

**Reset / Clear Form**