Renewal Application for Certification as a Yellow Fever Vaccination Center

Please PRINT or TYPE Requested Information

Applicant: _____
First Name Last Name Professional Title

Name of Clinic or Pharmacy _____

Address _____
Street

_____
City, State, and Zip Code

Phone No: ( ) _____ Fax No: ( ) _____

Contact Person for Application _____
First Name Last Name Title

Contact Person's e-mail address: _____

Physician Applicant AZ Medical License _____ Expiration Date _____

Pharmacy Applicant

AZ Pharmacy License Number _____

(If more than one pharmacy location is being applied for, attach sheet with names, addresses, telephone numbers, and AZ pharmacy license number information for all locations)

Supervising Physician's Name _____

Address _____

AZ Medical License _____ Expiration date_____

Nurse Practitioner Applicant

AZ Nurse Practitioner Certification_____ Expiration Date _____

_____

Signature of Applicant **Date**

	By checking this box, I attest that all of the health care providers and staff who provide yellow fever vaccine to patients have taken the CDC Yellow Fever online training program and will take it at least every 2 years.

Return this form along with an imprint of the Uniform Stamp (pharmacies must include their protocol) to: Arizona Department of Health Services, Immunization Program Office, 150 N. 18th Avenue, Suite 120, Phoenix, AZ 85007-3223. Telephone (602) 364-3630. Fax (602) 364-3285. Email: yellow.fever.vaccine@azdhs.gov

As of 5/26/2016