Bobby Jindal
GOVERNOR

Kathy Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Center for Community and Preventive Health
Yellow Fever Vaccination Center Certification Program

Application for the Uniform Stamp
for Authenticating International Certificate of Vaccination

Name of Physician Applicant_____
Mailing Address & Zip Code

_____

_____

Street Address (if different from above) _____

_____

Telephone No. ( ) _____

LA Medical License No._____
Address on license (if not the same as LA mailing or street address)

_____

_____

Federal DEA no._____

Name of Company, Institution or Organization for Whom the Applicant Provides Immunizations:

_____

Approximate No. of Yellow Fever vaccinations to be given per month_____ **and per year**_____

(optional - information for availability to the public): e-mail address:_____

Internet Web site:_____

APPLICANT'S PROMISE: I understand that the stamp is the property of the Department of Health and Hospitals, Office of Public Health and will be returned upon request. I agree to (1) keep the stamp when not in use in a safe place and not to loan it to any other person, (2) use the stamp only for certificates issued by me, (3) report immediately to the State Health Officer in case of loss or theft of the stamp, (4) return the stamp by registered mail at time of request for its return to the State Health Officer, and (5) administer the vaccine and complete the International Certificate of Vaccination in accordance with policies of the United States Public Health Service.

Signature of Applicant_____ **Date**_____

_____
Space Below This Line - For Office of Public Health Use Only

Stamp No._____ **Date Approved**_____
Impression of Stamp

_____
State Health Officer or Designee

FORM EPI 100
ADOPTED 4/99

PLEASE SEE NEXT PAGE FOR INSTRUCTIONS ON COMPLETING FORM

1450 Poydras Street, Suite 2013B ▪ New Orleans, Louisiana 70112
Phone 504/568-8120 ▪ FAX 504/568-8200 ▪ *WWW.DHH.LA.GOV*

Instructions for completing application form EPI 100:

Name:	First name, middle initial or name, and last name of physician applicant.
Mailing Address and Zip Code:	Street address or post office box, city, town, state and zip code, where all mail may be received.
Street address:	If different from above, include street address, where packages may be received.
Telephone no.:	Full telephone number, including area code, where the physician applicant may be reached during usual business hours.
LA medical license no.:	Give the physician applicant's Louisiana original license number, which does not change, <u>not</u> the annual registration no., which can change with each renewal of licensure.
Address (if different):	Some Louisiana licenses have an address on them, different from the mailing or street address given on this application, because of moving, e.g. from another state. If a different address appears on the license, please give it here.
Federal DEA no.:	Give the physician applicant's federal Department of Justice, Drug Enforcement Administration registration no. (not a requirement if physician has no DEA number)
Name of company, institution, etc.:	Complete if applicable, giving the name or names of firms, with whom the applicant physician has an agreement to administer yellow fever vaccinations (and others, if necessary).
Approximate no. of Yellow Fever, etc.:	Please give best estimate of number of yellow fever individual doses of vaccine to be administered each month and each year.
E-mail address and Internet Web site:	Complete, if applicable, and if the applicant agrees to have this information made public on the U.S. Centers for Disease Control and Prevention web site for certified Yellow Fever Vaccination Centers.
Applicant's Promise:	Applicant must read this completely and sign indicating full agreement.
Signature of Applicant:	This must be an original signature with the full name of the physician applicant.
Date:	Give month, day and year of signature on the application.