Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals
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 OVER FOR INSTRUCTIONS TO COMPLETE FORM

OFFICE OF PUBLIC HEALTH
P.O. BOX 60630 ▪ NEW ORLEANS, LOUISIANA 70160
PHONE #: 504/568-5048 ▪ FAX#: 504/599-0734 ▪ *WWW.YELLOWFEVER.DHH.LOUISIANA.GOV*