John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

Application for the Uniform Stamp For Authenticating International Certification of Vaccination

Name of Physician Applicant _____ LA Medical License # _____

Mailing Address and Zip Code
_____
_____

Address on License (if different from mailing)
_____
_____

Street Address (if different from above)
_____
_____

Federal DEA #: _____

Telephone #: _____

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

Approximate # of Yellow Fever vaccinations to be given per month _____ and per year _____

(optional – information to the public: e-mail address: _____
Website: _____

Applicant's Promise: I understand that the stamp is the property of the Louisiana Department of Health, 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 Louisiana Office of Public Health use Only

Stamp # _____ Date Approved _____
Impression of Stamp

_____
State Health Officer or Designee

Please See Next Page for Instructions on Completing Form

Instructions for completing the 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 #:	Full telephone number, including area code, where the physician applicant may be reached during usual business hours.
LA Medical License #:	Give the physician applicant's Louisiana original license number, which does not change, not 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 #:	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, institute (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).
Approx # of Yellow Fever:	Please give best estimate of number of yellow fever individual doses of vaccine to be administered each month and each year.
Email and Website:	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 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.