

Application to be a Yellow Fever Immunization Provider



Please PRINT or TYPE Requested Information.

Clinic Name: _____

Contact Person: _____
First Name Last Name Title

Contact Person's e-mail address: _____

Supervising Physician: _____
First Name M.I. Last Name Degree

Physician's State of Michigan License #: _____

Physician's DEA #: _____

Clinic Address: _____
Street City Zip Code County

Clinic Phone No: ____ / ____ Fax No: ____ / ____

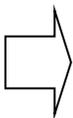
Days Clinic Open: (Check all that apply) Su M Tu W Th F S

Clinic Hours: ____ A.M. ____ P.M. Open to the Public? Yes No

Appointments required: Yes No Website address: _____

Services to be provided: General travel immunizations (i.e., hepatitis, MMR, Td)
 Yellow Fever vaccine
 Other services (please describe)

**Must
submit**



Please attach a narrative description of the supervising physician's experience in providing travel immunizations and their reason(s) for applying to be a travel immunization/yellow fever vaccine provider.

Supervising Physician's Signature

Date

RETURN THIS FORM TO: MDHHS – Division of Immunization
333 S. Grand Avenue
PO Box 30195
Lansing, MI 48909