COMMONWEALTH *of* VIRGINIA

Department of Health

Yellow Fever Vaccination Site Request

Name of Medical Provider: ____

Virginia State Medical License Number: ___________________________________

Name of Clinic: ____

Shipping Address: ____

____

Billing Address: ____

____

County/City: ______________________________

Phone: ________________________________; **Fax:** ___________________________

Email: __________________________________; **Web Site:** _______________________

Type of Request (Circle One): New Delete Provider Change Additional Provider

Can this location be listed on the Internet for the public (Circle One)? Yes No

Please scan and return this form to Richard.Bradley@vdh.virginia.gov. If unable to scan, fax to 804-864-8089

Note: Allow 3 to 5 weeks processing time.

VDH VIRGINIA DEPARTMENT OF HEALTH

Protecting You and Your Environment

www.vdh.virginia.gov