

STATE OF NEVADA

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
IMMUNIZATION PROGRAM

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VACCINE TRANSFER FORM

(Print Clearly)

Date: _____

PIN: _____ Clinic/Facility Transferring the Vaccine: _____

PIN: _____ Clinic/Facility Receiving the Vaccine: _____

I, _____, certify on behalf of the receiving clinic/facility, that our site is ENROLLED in the VFC and/or Adult Immunizations Program through the Nevada State Immunization Program (NSIP). I also certify that I have reviewed the last 3 months of the transferring clinic's vaccine storage unit temperature logs.

FOR OFFICIAL
USE ONLY

Temperatures During Time of Transport

Minimum _____ Maximum _____ Current _____

QTY (in doses)	VACCINE	VIAL/ SYRINGE	MFG	EXP DATE	LOT #	REASON FOR TRANSFER OR COMMENTS

Signature for Transferring Facility/Clinic

Signature for Receiving Facility/Clinic

Printed Name

Printed Name