- ANNUAL RENEWAL FORM -
YELLOW FEVER VACCINATION CENTERS

Physician Name: ____

Site where vaccine is administered:

Facility name: ____

Address: ____

City & Zip: ____

Stamp Number: 42 - _________ - ________________

Texas Medical License Number: ________________

Telephone Number: (______)________________ Fax: (______)_____________________

Contact Person: _______________________________________

Contact Email: ____

For the Reporting Period **1/1/2006 through 12/31/2006:**
Number of yellow fever vaccinations administered: _______________
Number of yellow fever vaccine Adverse Reactions: ______________

I wish to continue my authorization to administer yellow fever vaccine. I have administered 20 or more doses of yellow fever vaccine in the preceding year. Enclosed is my $25.00 fee and completed Annual Summary Form.

____ __________________
(Signature of Physician) (Date)

If you are not renewing, please return the validation stamp and this completed form to the address below.

The **Doctor's Name** and "**ZZ304-008**" **MUST** be written on the payment to expedite correct designation for these funds. Make checks payable to the Department of State Health Services. The $25.00 annual fee and this form, with original signature, should be mailed to:

Department of State Health Services
Immunization Branch attn: Bruce Chatmon
P.O. Box 149347
Austin, Texas 78714-9347

Please visit our website at: http://www.dshs.state.tx.us/immunize/vac_manage2.htm