

UNIFORM STAMP REPLACEMENT FORM Yellow Fever

Phys	ician Name and Suffix:			
Texas Medical License Number:		Stamp Number: 42		
Facil	ity Name:			
	ress:			
City:			Zin:	
Facility Phone: ()		·	•	
Facil	ity Website:			
Contact Person:		Direct Phone: ()	Direct Phone: ()	
Cont	tact Email:			
	upon receipt of the replacement stamp. Designated vaccination center will move to	rn or damaged. Please issue a new stamp. I will re a different county. Please issue a new stamp. I ha w address, county, contact information, and effec	ve attached, on facility	
I uno	derstand that the Uniform Stamp is the prop	perty of the Texas Department of State Health Se	ervices (DSHS). I agree to:	
1)	1) return the stamp to DSHS upon request;			
2)	keep the stamp in a secure place and never loan the stamp to others;			
3)	use the stamp only for International Certificates of Vaccination issued by me;			
4)	report to the Centers for Disease Control and Prevention (CDC) any adverse vaccine reactions;			
5)	administer vaccine in accordance with policies, requirements, and recommendations of the United States Public Health Service and CDC;			
6)	administer yellow fever vaccine only at the site designated on this form; and			
7)	submit the Annual Renewal Form and renewal fee every January in order to remain authorized.			
My	Signature of Physician	ement with this statement.	Date	

ZZ302 - 008 and the **Doctor's Name MUST** be written on the payment in order to ensure correct designation of these funds. Please mail this form and the **\$50.00** replacement fee to:

Cash Receipts Branch,
Texas Department of State Health Services
MC-2003
P. O. Box 149347
Austin, TX 78714-9347

Please allow 10 weeks to receive the replacement stamp.

Please visit our website at www.dshs.texas.gov/immunizations/what-we-do/vaccines/yellow-fever.