



# UNIFORM STAMP RETURN FORM

## Yellow Fever

Physician Name and Suffix: \_\_\_\_\_

Texas Medical License Number: \_\_\_\_\_ Stamp Number: 42 - \_\_\_\_\_ - \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip: \_\_\_\_\_

Facility Phone: (\_\_\_\_\_) \_\_\_\_\_ Facility Fax: (\_\_\_\_\_) \_\_\_\_\_

Facility Website: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Direct Phone: (\_\_\_\_\_) \_\_\_\_\_

Contact Email: \_\_\_\_\_

Communication regarding your yellow fever account is made primarily by email. Please select a permanent email address for your contact email, preferably the physician's.

Number of yellow fever vaccinations administered **1/1/2025 through 12/31/2025**: \_\_\_\_\_

Number of yellow fever vaccinations administered **1/1/2026 through present**: \_\_\_\_\_

Has your facility's authorization been renewed for the **2026** calendar year? ☐ Yes ☐ No

**NOTE:** If your facility has **ordered** or **administered** yellow fever vaccine during the current calendar year, a renewal application must be completed and submitted with payment to DSHS, even if service has since been discontinued. If you are unsure about your facility's renewal status, please contact the Yellow Fever Program.

**If you are not renewing**, the uniform stamp and this completed form (no payment) must be mailed to:

Immunization Section  
Texas Department of State Health Services  
MC-1946  
P. O. Box 149347  
Austin, TX 78714-9347

**My signature below acknowledges that I wish to discontinue my authorization to administer yellow fever vaccine at the facility stated on this form.**

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

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