VACCINE TRANSFER FORM

NORTH DAKOTA DEPARTMENT OF HEALTH

SFN 53766 (Rev. 1/13)

Transferring Provider			
Provider ID Number:	**Provider Name:**		**Date:**
Street Address:		**City:**	**Zip Code:**
Contact Person:		**Telephone No.:**	

Return this form to:

North Dakota Department of Health
Division of Disease Control
2635 East Main Ave. PO Box 5520
Bismarck ND 58506-5520
Fax Number: 701.328.2499

1. Complete this form when transferring vaccine.
2. Maintain proper vaccine temperature during transfer. For guidance on how to properly ship vaccine, see the CDC"s Vaccine Storage and Handling Toolkit http://www.cdc.gov/vaccines/recs/storage/toolkit/storage-handling-toolkit.pdf

Vaccine	Receiving Provider ID Number	Receiving Provider Name	Lot Number	Number of Doses
DT				
DTaP				
DTap/Hib/IPV (Pentacel®)				
DTaP/HepB/IPV (Pediarix®)				
DTap/IPV (Kinrix®)				
Hepatitis A				
Hepatitis B				
HIB				
HPV				
IPV				
Influenza				
MCV-4				
MMR				
MMR-V				
PCV-13				
PPV-23				
Rotavirus				
Shingles				
Td				
Tdap				
Varicella				
Reason for Transfer:				
Has this transfer been documented in NDIIS? YES ☐ NO ☐				

Contact the North Dakota Department of Health with any questions or concerns at 701.328.3386 or 800.472.2180