NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Yellow Fever Uniform Stamp Application

Provider Information:

Title: MD DO PA NP RPh DEA Number: _____

North Carolina Professional License Number: _____

First, Middle Initial, Last Name: _____

Email Address: _____

Facility Name: _____

Mailing Address: _____

Phone Number: _____

Fax Number: _____

Facility Website: _____

Clinic Hours of Operation: _____

Estimate of number of doses expected to be administered for the next 12 months: _____

Cost of administration fee: _____

Do you want to appear on the CDC "Find a Yellow Fever Clinic" website? Yes: ☐ No: ☐

- I agree to comply with all requirements from the Centers for Disease Control and Prevention (CDC) and the North Carolina Immunization Program (NCIP) pertaining to the use of the yellow fever uniform stamp.
- I understand that the Uniform Stamp is the property of the NCIP, and privileges can be revoked at the discretion of the branch.
- I agree to receive and administer yellow fever vaccine only at the site designated on this form. Vaccine must be shipped directly from the manufacturer to this location and not transferred between facilities.
- I acknowledge that I have read and understand the recommendations outlined by the CDC's Advisory Committee on Immunization Practices (ACIP) regarding the administration of yellow fever vaccine.
- I acknowledge that I understand that the VIS on yellow fever and it must be given to a patient prior to administering the yellow fever vaccine.
- I acknowledge that I have read and understand the requirements outlined by the NCIP for proper storage of yellow fever vaccine and will be compliant with the recommendations. I

understand that I must maintain vaccination and temperature logs and may be subject to an audit and asked to provide these logs for review. Failure to provide this documentation upon request may result in the cancellation of my stamp and ability to order vaccine.

- I understand that the uniform stamp is not to be used by others and if I, the certified uniform stamp holder, leave the assigned facility, the uniform stamp may not be retained by the facility, and I must reapply for designation of the new site which will include a new submission of a stamp application.
- I will notify the NCIP Help Desk (NCIRHelp@dhhs.nc.gov) of any changes to the original application or if I no longer provide the service.
- I agree in the event that my designated location closes, I will ensure patient records are archived according to the NC Medical Board located here.
- I agree to use the stamp only for International Certificates of Vaccination issued by me.
- I agree to report vaccine adverse events to the Vaccine Adverse Event Reporting System (VAERS). Additional information is available at https://vaers.hhs.gov or by telephone at 1-800-822-7967; 4)
- I understand certification expires three years from the date of issue. A North Carolina Yellow Fever Vaccination Center must recertify every three years to continue receiving vaccine.

My signature below acknowledges my agreement.

Signature of Applicant: _____

Date: _____

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Designation of Yellow Fever Vaccination Center

Only applicable if you are registering for more than one location

Name (Stamp Holder) Last		First	MI	Title (MD, DO. RN, NP, etc.) and License #	Lic. Expiry Date
Stamp holder of Record Address		City	County		Zip Code
Office Phone Number	Other Phone Number	Fax	Email Address		

Additional facility to be added as a designated Yellow Fever Vaccine Center

Additional stamp needed at this facility: ☐ **Yes** ☐ **No**

Name of Facility				
Designated Provider - Last		First	MI	Title (MD, DO. RN, NP, etc.)
Address		City	County	
Office Phone Number	Other Phone Number	Fax	Email Address	

Additional stamp needed at this facility: ☐ **Yes** ☐ **No**

Name of Facility				
Designated Provider - Last		First	MI	Title (MD, DO. RN, NP, etc.)
Address		City	County	
Office Phone Number	Other Phone Number	Fax	Email Address	

Additional stamp needed at this facility: ☐ **Yes** ☐ **No**

Name of Facility				
Designated Provider - Last		First	MI	Title (MD, DO. RN, NP, etc.)
Address		City	County	
Office Phone Number	Other Phone Number	Fax	Email Address	

Applicant Signature	Date

You may attach additional sheets as needed.