

Immunization Input Form for Health Care Providers

Clinic/Facility/Agency (service delivery location) _____ Person submitting form _____
 City/Town/Community _____ Contact Phone Number _____
 Organization type (if known - i.e. Occ. Health, Long Term Care) _____ Date Submitted _____

For Influenza Only
 Facilities (PCHs/Hospitals) and Occupational Health
 Document Reason for Immunization Code
 (1) Residents or Patients
 (2) Staff
 (3) Visitors, Volunteers etc.

Please submit completed forms as soon as possible to your local Public Health Office (link to list of public health offices - gov.mb.ca/health/publichealth/offices.html)

| Client PHIN (9 digit health #) | Last Name | First Name | Date of Birth (YYYY-MM-DD) | Gender (M / F) | Vaccine Name | Tariff Code (if known) | Date Given (YYYY-MM-DD) | Lot Number (if available) | Reason for Influenza Code | Provider Name |
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