



VACCINE TRANSFER FORM
 NORTH DAKOTA DEPARTMENT OF HEALTH
 SFN 53766 (Rev. 3/10)

<u>Transferring Provider</u>		
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.

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

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