Vaccine Transfer Request Form

(State-supplied vaccines only)

Date of Request _____

Transferring Provider: _____ Provider's PIN: _____

Contact Person: _____ Phone: _____

Email: _____ Fax: _____

Receiving Provider: _____ Provider's PIN: _____

Contact Person: _____ Phone: _____

Email: _____ Fax: _____

I would like to request permission to transfer the following vaccines.

Vaccine	Doses	Lot Number	Expiration Date

Reason for Transfer: ☐ Short Dated ☐ Over Stocked ☐ Other

Other (must detail reason) _____

Email or fax form to the Alaska Immunization Program for approval. Once Immunization Program staff have approved the request, both providers will receive notice via email. After providers have received approval, the vaccine transport may then occur. Ensure the cold chain is maintained at all times during transport using appropriate vaccine transport methods.

Approval by Immunization Program Staff _____ Date: _____

Date Completed in VacTrAK: _____

Alaska Immunization Program
Phone: 907-269-8088 | Fax: 907-269-0478 | Email: vaccinedepot@alaska.gov
Website: https://health.alaska.gov/dph/Epi/iz/Pages/default.aspx

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