



VACCINE TRANSFER FORM IMMUNIZATION PROGRAM



410 Capitol Avenue, MS# 11MUN
Hartford, CT 06134-0308 ProgramPhone (860) 509-7929 / Fax (860) 509-8371

**This form is to be used in the event of transferring viable vaccine
from provider to provider**

Transferring Provider Instructions:

1. Notify the State Immunization Program and local IAP Coordinator (if applicable) of the intent to transfer vaccine.
2. Complete the transfer form in its entirety.
3. Follow cold chain instructions including transporting vaccine in an insulated container with cold packs.
4. Both providers need to sign and date the bottom of this form upon the date of actual transfer.
5. Document each transfer on your Vaccine Order Form and keep a copy of this form for your records. Be sure to fax a copy of this form to the Immunization program at (860) 509-8371. To download additional forms please go to www.ct.gov/dph/immunizations

Cold Chain Instructions:

1. For refrigerated vaccines: keep cold at 35 to 45 degrees, do not freeze. Use refrigerated or ice packs (frozen ice packs for hot weather, refrigerated packs for cold weather)
2. Make sure vaccines are kept in their original boxes. Place insulation (crumpled paper or bubble wrap) between vaccines boxes and refrigerated or frozen ice packs to prevent vaccine freezing. Put crushed paper in cooler to keep vaccines from shifting during transport.
3. Do not leave vaccine container unattended or in the trunk of your car.
4. For frozen vaccines (varicella, MMRV): place a thermometer in the cooler and pack enough dry ice to maintain temperature of 5 degrees or colder.

	Transferring Provider Pin #
Name:	Date:
Address:	Phone:
City & State:	Person Completing Form:

Providers Receiving Transferred Vaccine

1. Upon Arrival of vaccine, check the quantities and lot numbers against what is listed below.
2. Sign and date the bottom of the form in the appropriate place (Signature of Receiving Provider).
3. Store vaccines immediately.

Vaccine	Lot Number (s)	Dose(s)	Expiration Date (s)	Receiving Provider PIN #

Signature of Transferring Provider: _____ Date: _____

Signature of Receiving Provider: _____ Date: _____