Penn Medicine
Princeton Health

Influenza Vaccination Received At Another Facility

Name: _____ Date of Birth: _____

Department: _____ **8-DIGIT PENN ID NUMBER**: _____

FOR EMPLOYEES ONLY, FORMS WITHOUT PENN ID NUMBER WILL BE REJECTED AND RETURNED. ****PENN ID NUMBER IS ON THE BACK OF YOUR ID BADGE****

Please check one: ☐Employee ☐Physician/ PA/ NP ☐Volunteer ☐Consultant, Contractor

I certify that I have received influenza vaccination at another facility and the information is as follows:

Name of location: _____

Address of location: _____

Trade name of influenza vaccine: _____

Date given: _____

L or R arm given: _____

Vaccine lot number: _____

Manufacturer's name: _____

Employee signature: _____Date:_____

Please scan this form and **EMAIL** to: PMPH-fluform@pennmedicine.upenn.edu

EMAIL THIS FORM AND CLICK ON THE OUTLOOK "READ RECEIPT" BUTTON IF YOU WANT PROOF THAT THE FORM WAS RECEIVED BY OCCUPATIONAL HEALTH

Or mail to:

Penn Medicine Princeton Medical Center
Occupational Health
5 Plainsboro Road, Suite 570
Plainsboro, NJ 08536