

Section A - Health Unit Information

Name of Health Unit: **Peel Public Health**

Report Completed by: _____

Telephone # : 905-791-7800 ext.: _____

Fax # : 905-565-9874

Section B - Facility Information (TO BE COMPLETED BY FACILITY)

Reason for Vaccine Return (Please Select) Expired Vaccine Cold Chain Failure Excess Vaccine

Other Reasons for Return: (Please Specify) _____

Name of Facility: _____ HP Code # RMP_MS_: _____

Facility Contact Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Return to Peel Public Health (YYYY/MM/DD) _____

Cold Chain Incident

Date: _____

Time: _____

Reported to Peel Public Health Yes No

Please return vaccine to Peel Public Health with your next vaccine pick-up or delivery

V-07-739 17/06

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