**VACCINE RETURN FORM**

**THIS FORM MUST ACCOMPANY ALL VACCINE RETURNS**

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| **Health Care Provide/Pharmacy Name:** | **Phone #:** |
| **Date of Return:**  | **Date of Cold Chain Incident (if applicable):**  |

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| --- | --- | --- | --- | --- |
| **Name of Vaccine** | **# of doses** (not # of boxes) | **Lot #** | **Expiry Date** | **Reason for Return**(see codes below) |
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**Prior to returning vaccine due to any reason other than expired product, please**

**call 519-663-5317 to discuss with a Public Health Nurse first.**

**Please write code in the “Reason for Return” column:**

**CCH**- Cold Chain Incident (Human Error)

**CCM** – Cold Chain Incident (Fridge/Equip. Malfunction)

**CCP** – Cold Chain Incident (Power Outage)

**DP** – Damaged Product

**EX** – Expired Product

**FC** – Facility Closure