BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

VACCINE RETURN FORM

Fax to: 519-663-9581

THIS FORM MUST ACCOMPANY ALL VACCINE RETURNS

From: _____
(Physician/Clinic Name)

Date of Return: _____

Date of Cold Chain Incident (if applicable): _____

- ***DO NOT* write # of boxes – please write in # of doses returned**

Name of Vaccine	# of doses	Lot #	Expiry date	Reason for return

Reason for return codes:

OG – expired
XP – cold chain break
UP – unsuitable for use (ie broken, damaged)
ER – power outage