Proof of Influenza Vaccination

Patient Name: _____

Clinic Location: _____ Clinic Date: _____

Flu DX Code: **Z23** Flu CPT Code: **90658** Flu Admin Code: **90471**

Mfg: _____ *Lot #:* _____

Signature: _____

(Authorized OccuVax Representative)

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your onsite clinic specialists

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