Kansas Immunization Program
Vaccine Transfer Form

Date: _____ **Transferring Unit Name/Identifier:**_____

Transferring Provider: _____ **PIN:** _____

Receiving Provider: _____ **PIN:** _____

Regional Immunization Consultant Authorizing Transfer: _____

Vaccine	Lot #	Manufacturer	Expiration	Dose Count	Funding Source

Transferring Unit Temp/Time: _____ **Receiving Unit Temp/Time:** _____

Hourly Temps:

Time: _____ Temp: _____	Time: _____	Temp: _____	
Time: _____ Temp: _____	Time: _____	Temp: _____	
Time: _____ Temp: _____	Time: _____	Temp: _____	
Time: _____ Temp: _____	Time: _____	Temp: _____	

Signing staff attest to the above documented temperatures and verified vaccine counts done within the stated transport date.

Transferring Staff Signature: _____ **Date:** _____

Receiving Staff Signature: _____ **Date:** _____

***Vaccine transfers MUST be completed in KSWebIZ within current reconciliation period.**