Immunization Record Request Application

Please print clearly.

Applicant's Information (Information for the person whose record is being requested.)

First name _____ Middle name _____

Last name _____ Maiden name (Last name before first marriage, if applicable) _____

Sex assigned at birth ☐ Male ☐ Female Born in NYC? ☐ Yes ☐ No

Date of birth (MM/DD/YYYY) _____ Medicaid number (if applicable) _____

Phone number _____ Email address _____

Address _____ Apartment number _____

City _____ State _____ ZIP code _____

Name of the hospital where the applicant was born _____

Current health care provider's name _____

Current health care provider's phone number _____

Instructions to request a record by mail:

1. Complete the application.
2. Attach a copy of a valid photo ID, such as an IDNYC card, a driver's license, or a passport.
3. Mail the completed application and copy of the ID to:
   NYC Health Department
   Citywide Immunization Registry
   42-09 28th St.
   Fifth Floor, CN-21
   Long Island City, NY 11101-4132

You will receive a response within 10 business days. Do not email this application.

For more information or to request a print copy of this form, call **311**, visit **nyc.gov/health** and search for **vaccine records**, or email **cir@health.nyc.gov**.

We help you call the shots! CIR

For Official Use Only

Form received on: _____

Status of request:

☐ Record sent on: _____
☐ Record not found
☐ Record found — no vaccines
☐ Form incomplete

Staff initials: _____

Applicant's Mother Information

Mother's first name _____ Mother's last name _____

Mother's maiden name _____ Mother's date of birth (MM/DD/YYYY) _____

Parent or Guardian Information (If the person requesting the record is not the applicant.)

Relationship to applicant ☐ Mother ☐ Father ☐ Guardian ☐ Other (describe): _____

First name _____ Last name _____ Email address _____

This is to certify that I am the applicant, or the parent, guardian, or other person in a custodial relation to the applicant, and, as such, I am authorized to view the requested information. I understand that submitting false, untrue, or misleading information to the New York City Department of Health and Mental Hygiene is a violation of NYC Health Code §3.19. I further understand that each incident of such violation is punishable by civil penalties up to $2,000 pursuant to New York City Health Code §3.11.

Signature of applicant or parent or guardian requesting the record _____ Date _____ Primary language of applicant or the parent or guardian requesting the record _____