NEW YORK STATE DEPARTMENT OF HEALTH
Vaccines for Adults Program Monthly Doses Administered Report

Provider Name: _____

Address: _____

Contact Name: _____ Title: _____

Telephone: _____ Fax: _____ Email: _____

County: _____ Month/Year_____

*Providers must report vaccines administered to adults 19 years and older (with patient consent for reporting), to the New York State Immunization Information System (NYSIIS). The Monthly Doses Administered report shall only be used to report dose administered to adults who do **NOT** consent to NYSIIS reporting*

Doses Reported to NYSIIS

☐ All (100%) – *No further reporting necessary*
☐ Some (1 – 99%) – *Report only those doses not reported to NYSIIS in the Doses Administered table below*
☐ None (0%) – *Complete the Doses Administered table below*

Doses Administered (Report only those doses **not** reported to NYSIIS). Use additional pages if needed.

	Uninsured	**Underinsured**	**Fully Insured Post-Secondary**
PIN _____			
Hepatitis A			
Hepatitis B			
Hepatitis A/B (Twinrix®)			
HPV			
Meningococcal			
MMR			
PCV13			
PPSV23			
Tdap			
Td			
Influenza			
	Uninsured	**Underinsured**	**Fully Insured Post-Secondary**
PIN _____			
Hepatitis A			
Hepatitis B			
Hepatitis A/B (Twinrix®)			
HPV			
Meningococcal			
MMR			
PCV13			
PPSV23			
Tdap			
Td			
Influenza			