



Government of the District of Columbia  
Department of Health  
Health Regulation and Licensing Administration



**YELLOW FEVER STAMP OWNER APPLICATION**

**For Official Use Only**

Approved <input type="checkbox"/> Denied <input type="checkbox"/>	Stamp Number: YF _____
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Please Print or Type: **(ALL SECTIONS MUST BE COMPLETED AND SENT TO ADDRESS BELOW)**

Indicate type Health Professional License:  Pharmacist  Physician  Nurse

Health Professional License #: \_\_\_\_\_

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Home Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip code

\_\_\_\_\_  
Business Name

\_\_\_\_\_  
Business Address (Suite/Building/Floor)

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip code

\_\_\_\_\_  
Business Number

\_\_\_\_\_  
Cell Number

\_\_\_\_\_  
Business Fax Number

\_\_\_\_\_  
Email Address

**Attestation**

I agree to comply with all guidelines established by the District of Columbia Department of Health pertaining to the use of the Yellow Fever Uniform Stamp. I understand that the stamp remains the property of the Department of Health and is subject to recall at the discretion of the Department.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date