Reset Form

VACCINE RETURN

State Form 54052 (R / 3-11)
Indiana State Department of Health, Immunization Division

INSTRUCTIONS: *1. Complete and return this form to the Indiana State Department of Health (ISDH) Immunization program.*
*2. Only complete for publically funded vaccines. **You must dispose of privately purchased vaccine yourself**.*
3. Fax a copy to (317) 972-8964. Include a copy of this form with returned vaccine. Retain a copy of this form for your records.

A. Provider Information

Date *(month, day, year)* _____

Facility Name _____ Provider PIN Number _____

Contact Name(s) _____ Email Address _____

B. Do you have insurance (that covers vaccine loss)? ☐ Yes ☐ No Deductable amount $ _____

C. Do you need a Vaccine Return Shipping Label? ☐ Yes ☐ No How Many Labels? _____

D. *Will be sent directly from McKesson. Please allow 7-10 business days for label to arrive via USPS.*

E. Reason for Return *(Check one only)* *If reason is not found on this list, please contact the Vaccine Manager.*

☐ Expired - Contact ISDH 60 days prior to expiration to transfer
☐ Expired - Short-dated when received
☐ Refrigeration failure/Power outage
☐ Did not store properly
☐ Did not store properly upon receipt
☐ Single dose spoilage not related to improper storage**
☐ Lost or unaccounted for in provider inventory
☐ Theft
☐ Other _____

***Under 5 doses does not require this form. Report on Vaccine Order form under Wasted.*

F. Please provide additional details regarding the vaccine loss. *Use additional pages if needed.*

_____

_____

_____

G. Action taken by On-Site Staff *(Check all that apply.)*

☐ Contacted ISDH and/or Field Representative
☐ Contact Vaccine Manufacturer to determine viability
☐ Adjust refrigerator temperatures
☐ Maintained vaccine at required temperatures, may require alternate storage unit
☐ Other _____

H. List Vaccine to be Returned *(Transfers should be documented and requested on the Vaccine Transfer Form.)*

Vaccine	Number of Doses	Manufacturer	Lot number	Expiration Date *(month, day, year)*

Additional vaccine can be listed on next page, if needed.

Signature_____ Date *(month, day, year)*_____

For Office Use Only

Date Form Received *(month, day, year)* _____ Form Processed by _____

Actions Taken *(Check all that apply.)*

☐ Return Label Requested
☐ Vaccine Loss Letter & Cost Total Sent
☐ Field Representative Notified
☐ Reimbursement Completed
☐ Action Plan Created

Only complete this page for vaccine not listed on first page.

Facility Name _____ Provider PIN Number _____

I. List Vaccine to be Adjusted *(continued)*

Vaccine	**Number of Doses**	**Manufacturer**	**Lot number**	**Expiration Date** *(month, day, year)*

Signature_____ Date *(month, day, year)*_____