Immunization Record Correction Form for Health Care Providers

Clinic/Facility/Agency (service delivery location) ____________________

City/Town/Community ____________________

Date Submitted ____________________ yyyy-mm-dd

Person submitting form ____________________

Contact Phone Number ____________________

Please submit completed forms by fax to 204-945-6482

Please correct the immunization record of the following patient/client

Patient/Client Information

Last Name ____________________ **First Name** ____________________

Client PHIN ____________________ (9-digit health #) **Client DOB** ____________________ yyyy-mm-dd

Change Request:

- Document all data elements of the current record as displayed in the provincial immunization registry.
- Complete action required for each data element to be changed – delete record or change
- List the corrected data element(s) under "New Record".

Data elements of Current Record		**Action Required** (check all that apply)	**New Record** (list changes in the required data elements)
Name of Vaccine		☐ Delete record – entered in error ☐ Delete record - duplicate ☐ Change	
Date Administered	yyyy-mm-dd	☐ Change	
Provider Name		☐ Change	
Service Delivery Location		☐ Change	
Comments:			

Additional Vaccines (for the above named client)

Document the vaccines that need to be added to the provincial immunization registry in the table below.

Date Administered	Vaccine Name	Manufacturer (if known)	Lot # (if known)	Dosage	Site	Provider name
yyyy-mm-dd						
yyyy-mm-dd						
yyyy-mm-dd						

January 2025