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. *Email a copy to vaccine@isdh.in.gov or fax a copy to (317) 972-8964. You will be forwarded a transaction form that will need to be submitted with the vaccines and a return label will be emailed to you.*

A. Provider Information

Date *(month, day, and year)* ________________

Facility Name ____ Provider PIN Number ______________

Contact Name(s) _______________________ **Email Address** ____________________________________

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

C. Do you need a Vaccine Return Shipping Label? ☐ Yes ☐ No How Many Labels? _____________________
All return labels will be sent directly from McKesson via email to the email address listed above. The email should arrive within 2-5 business days.

D. Reason for Return (*Include letter for return reason in table below*):

A. Expired
B. Failure to store properly upon receipt
C. Mechanical Failure
D. Natural Disaster
E. Refrigerator too cold
F. Refrigerator too warm
G. Spoiled – other
H. Vaccine spoiled in transit
I. Broken Vial/syringe
J. Lost or unaccounted for in provider inventory
K. Open vial but all doses not administered
L. Vaccine drawn into syringe by not administered
M. Other ___________________________________
____

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

Return Reason	Vaccine Brand Name	Vaccine NDC #	Lot number	Expiration Date *(month, day, year)*	Number of Doses

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

Signature ____ Date *(month, day, and year)* ______________

For Office Use Only

Date Form Received *(month, day, and year)* __________ Form Processed by ______________________________________

Actions Taken *(Check all that apply.)*

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

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

Facility Name ____ Provider PIN Number __________________

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

Return Reason	Vaccine Brand Name	Vaccine NDC #	Lot number	Expiration Date *(month, day, year)*	Number of Doses

Signature____ Date *(month, day, and year)*________________