Immunization Record Request Application

Please print clearly.

Applicant's Information (information for the person whose records you are requesting)

First Name _____ Middle Name _____

Last Name _____

Sex Assigned at Birth ☐ Male ☐ Female Born in NYC? ☐ Yes ☐ No

__ __ / __ __ / __ __
Date of Birth (month/day/year)

__ __ __ __ __ __ __ __ __ __
Medicaid Number (if applicable)

__ __ __ - __ __ __ - __ __ __ __
Phone Number

__ __ __ - __ __ __ - __ __ __ __
Fax (if you are requesting the record by fax)

Address _____ Apt. _____

City _____ State _____ ZIP Code _____

Name of Hospital Where Applicant Was Born _____

Health Care Provider's Name _____

Health Care Provider's Phone Number __ __ __ __ __ __ __ __ __ __

Information of Applicant's Mother

Mother's First Name _____ Mother's Maiden Name (last name before first marriage) _____

__ __ / __ __ / __ __
Mother's Date of Birth (month/day/year)

Parent Information (If applicant is a minor, select your relationship to the child.)

☐ Mother ☐ Father ☐ Guardian ☐ Other (describe) _____

First Name _____ Last Name _____

Email Address _____ Primary Language (if not English) _____

Instructions to request a record by mail or fax:

1. Complete the application.
2. Attach a copy of a valid photo ID, such as an IDNYC card, driver's license or passport.
3. Mail the completed application and the copy of ID to:

NYC DOHMH
Citywide Immunization Registry
42-09 28th Street, 5th Fl., CN 21
LIC, NY 11101-4132

Or fax it to 347-396-8840.

Please do not email this application.

You will receive a response within ten business days if you submitted the application by mail, or within two business days if you submitted the application by fax.

We help you call the shots! CIR

For Official Use Only

Form Received on ___/___/____
Status of Request:
☐ Record Sent on ___/___/_____
☐ Record Not Found
☐ Record Found, No Vaccines
☐ Form Incomplete
Staff Initials: _____

This is to certify that I am the parent, guardian, or other person in custodial relation to the child whose information is listed above for the immunization record search, and as such, I am authorized to view the information; or I am the individual to whom the record relates. I understand that submitting false, untrue or misleading information to the Department of Health and Mental Hygiene is a violation of New York City Health Code §3.19. I further understand that each incident of such violation is punishable by civil penalties up to $2,000 pursuant to New York City Health Code §3.11.

Signature of Applicant or Parent (if the applicant is a minor) _____ **Date** _____

For more info, or to request a print copy of this form, call 311, visit **nyc.gov/health/cir** or email **cir@health.nyc.gov**.