

COVID-19 Vaccine Transfer Request

West Virginia Joint Inter Agency Task Force

Transfer Submitted By:

Provider Name: _____

Point-of-Contact Name: _____

Phone: _____

Signature: _____

Date: _____ **Time:** _____

Vaccine Received By:

Provider Name: _____

Point-of-Contact Name: _____

Phone: _____

Signature: _____

Date: _____ **Time:** _____

Current Vaccine Temperature: _____

Quantity (specify number of vials)	Manufacturer	Lot #	Expiration

Both parties must sign off on the vaccine count. Only vaccine doses documented on this form are authorized for transfer.