Lakelands Public Health

Return Form for Vaccines and Passive Immunizing Agents

Please complete and attach this form to your vaccines for return

Return Date (YYYY/MM/DD):

Facility Name/Health Care Provider Name: | **Suite #:**

Contact Name: | **Telephone Number:**

Abbreviation	Lot Number	Expiry Date *(YYYY/MM/DD)*	Doses Returned	Return Code*
DTaP-IPV-Hib				
IPV				
Men-C-C				
MMR				
MMRV				
Pneu-C-15				
Pneu-C-20				
PPD				
Rab				
Rablg				
Rot-1				
RSV				
RSVab				
Td				
Tdap				
Tdap-IPV				
Var				
HZ				
Hep B				
HPV-9				
Men-C-ACYW135				
Act-Hib				
HA				
HB				
MenB				
Influenza				
Influenza HD				
Diluent				

***RETURN CODES:**

CCM: Cold chain incident/malfunction – refrigerator/freezer/equipment; **CCH**: Cold chain incident – human error; **CTP**: Cold chain incident – temperature breached in transit; **CCE**: Cold chain incident – emergency/natural disaster; **CCP**: Cold chain incident – power outage
DI: Discontinued product; **EQ**: Excessive quantity; **EX**: Expired product; **FC**: Facility Closure; **RP**: Recalled product; **DP**: Damaged product