CERTIFICATION OF YELLOW FEVER VACCINATION CENTRES APPLICATION FORM

Type of application (Please tick appropriate category)

1. **First application for certification of medical practice as a Yellow Fever Vaccination Centre** ☐
2. **Application for re-certification of medical practice as a Yellow Fever Vaccination Centre** ☐
3. **New applicant medical practitioner to become an approved clinician following joining an existing approved Yellow Fever Vaccination Centre** ☐

Name of Medical Practice:

Practice Address:

Eircode: Phone Number:

Email address(es)

Website Address:

Appendix 1 (Page 2 of 3)

(*Tick appropriate box below)*

1. Designated Medical Practitioner(s) applying for certification of medical practice as a certified Yellow Fever Vaccination Centre

I / we wish to apply for the above medical practice to be certified as a Yellow

Fever Vaccination Centre ☐

2. Designated Medical Practitioner(s) applying for re- certification of medical practice as a certified Yellow Fever Vaccination Centre.

I / we wish to apply for the above medical practice to be re-certified as a Yellow Fever Vaccination Centre ☐

3. New applicant clinicians (medical practitioners or nurses) joining an existing certified Yellow Fever Vaccination Centre

I wish to apply for my name to be added to the list of approved medical practitioners to administer Yellow Fever Vaccination at the above certified Yellow Fever Vaccination Centre

☐

Note: Approval is person-specific and centre-specific. Only medical practitioners and nurses with current, approved Yellow Fever training may prescribe (medical practitioners only) or administer Yellow Fever vaccine. They can only prescribe (medical practitioners only) or administer Yellow Fever vaccine at a

certified YFVC.

Applies to all above

I / we hereby agree to follow the International Health Regulations (2005) 3rd edition requirements as described in Annexes 6&7 (**Appendix 2**) ☐

I / we will adhere to the guidelines and conditions of registration as a YFVC as outlined in **Appendix 3** and **Appendix 4**, including requirements relating to approved clinicians, training, and scope of practice, if approval is granted ☐

Please attach a copy of your Irish Medical Council (IMC) or Nursing and Midwifery Board of Ireland (NMBI) Certificate of Registration. Alternatively insert a website link to your live registration status: https://www.medicalcouncil.ie/public-information/check-the-register/

Appendix 1 (Page 3 of 3)

	Name of Applicant Medical Practitioner (Block Capitals)	IMC/NMBI Registration No
Signed		
Signed		
Signed		

***(New medical practitioner (s) or nurses joining a certified YFVC must be signed off below by the Designated Medical Practitioner)**

Signed:

Date: