CENTRAL VALLEY HEALTH DISTRICT
IMMUNIZATION RECORD REQUEST
122 2ND ST. NW, JAMESTOWN, ND 58401
PHONE: 701.252.8130 FAX:701.252.8137

Immunization Record Request		
Method for Receiving Request:	☐ **In-Person.**	Must pick up from CVHD in Jamestown. Please allow 2 business days for your request to be processed.
	☐ **Mail.**	To address listed below.
	☐ **Email.**	To email address listed below.

Requested Immunization Record Information *Who is the request for?*			
First Name:		Middle Name:	
Maiden Name:		Last Name:	
Date of Birth:		Gender: ☐ Male	☐ Female

Requestor's Information			
Requestor's Last Name:		Requestor's First Name:	
Relationship: ☐ Self	☐ Parent	☐ Guardian (provide release of information form)	
Street Address:			
City:		State:	ZIP Code:
Telephone Number:	Email Address:		

☐ By checking this box and typing my name below, I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature. I agree that the electronic signature appearing on this document has the same validity and enforceability as a handwritten signature.

Signature:	Date:

Central Valley Health District *(For Office Use Only)*			
Date Received:		Date Fulfilled:	
Fufilled by: (initials)	☐ Record Distributed	☐ Record Not Found	

Send the completed request to **kclee@nd.gov**. Allow 2 buisness days for request to be processed.

Please bring a form of identification (i.e. Driver's License) when picking up the requested document.