Thunder Bay District Health Unit

Request of Immunization Record

Surname: _____

First name: _____

Maiden name: _____

Other Name: _____

Date of Birth: _____

Fax number you would like your record faxed to: _____
(include area code)

Mail immunization record to: _____
(name)

_____
(address)

_____
(city)

_____
(postal code)

For more information or to speak with a nurse, please call 625-5971 or 1-888-294-6630, ext. 5971.

Visit our website at TBDHU.com

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