2017

ASIIS Request Withdrawal Form

(602) 364-3899

ADHS – Immunization Office/ASIIS
150 North 18th Avenue, Suite 120
Phoenix, Arizona 85007-3233

DIRECTIONS: Please fill out of this form and email it back to us. If you have any questions, please call us.

Name:____
Address:____
City:____ State: ____ Zip:____________________
Phone #: (_____)__________________________

Please complete the information below.

Name:	
SSN: (Optional)	
Date of Birth	Gender:
Address:	
City:	Zip:

I request that my immunization record be suppressed in the ASIIS registry. Please suppress all information that is currently showing in the registry. I realize that the "Lifetime Immunization Record" card will be my only record of immunizations.

My reasons for withdrawal are:

Name: ____

(Signature) (Date)