Office of Practice and Professional Graduate Program
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SCHOOL OF NURSING
UNIVERSITY OF MICHIGAN

VERIFICATION OF SEASONAL FLU SHOT ADMINISTRATION

TO BE FILLED OUT BY THE STUDENT

First Name		Last Name	
Uniqname	UM ID	Phone Number	

TO BE FILLED OUT BY THE HEALTHCARE PROVIDER

SEASONAL FLU SHOT ADMINISTRATION			
Date Administered		Flu Vaccine Batch (i.e., 2017-2018 batch)	
Healthcare Provider's Name and Title (Please Print)			
Signature			
Healthcare Center/Facility			
Address	City	State	Zip
Phone		Email Address	