



DEPARTMENT OF THE AIR FORCE

F E WARREN AFB

CHEYENNE, WY

Date: _____

MEMORANDUM FOR: Medical Treatment Facility

FROM: FSS/FS

SUBJECT: Immunization Clearance

1. _____ has been selected for relocation to _____ with a departure date of _____.

2. Please take action to ensure member and dependents (if applicable) are administered all immunizations and test checks required by *AFJI 48-110, Immunizations and Chemoprophylaxis*.

Signed
FSS/FS

1st Ind, Medical Treatment Facility

Date: _____

TO: FSS/FS

() All immunizations and test checks required by *AFJI 48-110, Immunizations and Chemoprophylaxis* have been completed.

() This medical unit is unable to complete required immunizations due to lack of time or non-availability of vaccine. Member has been advised to obtain the required immunizations at his/her next duty station.

(Name, Grade of Immunizations Clinic Representative)