



COVID-19 Vaccination Event Request Form

Location Name: _____
Street Address: _____
City: _____
County: _____
Zip Code: _____

Point of Contact (POC) Name: _____
POC Phone #: _____
POC Email: _____
Alternate POC: _____
Alternate POC Phone #: _____
Alternate POC Email: _____

Date(s) of Event: _____
Time of Event: _____

Estimated # of Vaccines: _____

Vaccine type*:
(Mark one or more)

- Pfizer
- Moderna
- Johnson and Johnson

*Vaccine type request will be taken into consideration but cannot be guaranteed.

Comments:

Please remit form to:
marcia.woodham@flhealth.gov
dana.heinlein@flhealth.gov