DALLAS NURSING INSTITUTE
12170 North Abrams Rd. • Suite 200 • Dallas, TX 75243 • Phone: 469-941-8307 • Fax: 214-575-9090

Immunization Record Request Form

Name_____ _____ _____
Last Name (While enrolled) First Name Middle Initial

Social Security Number _____ Date of Birth _____

Current Address_____

City_____ State_____ Zip Code_____

Phone Number_____

Program_____ Graduation Date_____

Please allow 7 to 10 business days to process your request for immunization records. Limited 1 request only. All immunization record requests must be picked up at Dallas Nursing Institute by the graduate student. I give Dallas Nursing Institute permission to release my immunization records as directed above.

Signature_____

Print Name_____

Date_____

This immunization request form may be mailed or faxed to:

Dallas Nursing Institute
12170 North Abrams, Suite 200
Dallas TX, 75243
Fax: 214-575-9090 or registrar@dni.edu