



**NEW YORK STATE DEPARTMENT OF HEALTH
TAMIFLU (Oseltamivir Phosphate) REQUEST FORM**

REQUEST DATE: _____

COUNTY NAME: _____

SHIPPING ADDRESS (Facility Name): _____

(Street) _____ (City) _____ (State) _____ (Zip) _____

REQUESTOR NAME: _____ REQUESTOR TITLE: _____

REQUESTOR PHONE NUMBER: () _____ EMAIL: _____

Please provide the following information:

- | |
|---|
| <p>1. Have all other methods of procuring Tamiflu been exhausted as per the latest NYSDOH Guidance? Yes or No</p> <p>2. Total number of bottles of Tamiflu Suspension being requested _____</p> <p>3. Total number of bottles of Tamiflu 75mg being requested _____</p> |
|---|

For NYSDOH use only:

Date of Review: / / 200 Approved: Yes No

Approved by: _____ Title _____

Date of Shipment: / / 200 Quantity of