

**Pfizer Comirnaty® COVID-19 Vaccine Registration Form  
12 Years and Older**

**\*\*\*\*PRINT LEGIBLY\*\*\*\***

HCP = Health Care Provider

Fax to 306-787-6296 or 306-787-6259 or Scan both sides and email to: [Panoramareportimms@health.gov.sk.ca](mailto:Panoramareportimms@health.gov.sk.ca)

- Complete every field      Print legibly
- Do not use abbreviations unless specified
- Review for completeness before submitting
- Submit only 1 line list per email
- Provide a contact name and phone number in the email in case follow-up is needed.

Date: _____ Clinic Location (Site and City/Town): _____ HCP Name (Printed): _____ HCP Designation: <input type="checkbox"/> Physician <input type="checkbox"/> RN HCP Name (Signature): _____ <input type="checkbox"/> Other _____	<b>Vaccine Name: Pfizer Comirnaty® 12+ COVID – 19 VACCINE</b> <b>Lot Number:</b> _____ <b>Dose: 0.3 ml</b> <b>Route: IM</b>
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	HSN	LAST NAME	FIRST NAME	DOB	GENDER	SITE	COMMUNITY/CITY OF RESIDENCE	Consent Granted	VACCINE GIVEN: HCP INITIALS	Entered on Panorama
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\*\*\*USE BOTH SIDES OF FORM\*\*\*

\*\*\*\*SCAN BOTH SIDES OF THE FORM\*\*\*\*

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