ADVANCED ALLERGY IMMUNOLOGY & ASTHMA, P.C.
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Vial Request Form

Patient Name:_____ DOB:_____ Date:_____

Are vials going to be **Picked Up** or **Mailed Out** (Please Circle One)

Shipping address (*Must be included when submitting vial request*)

Name of Person/Facility:_____

Street Address:_____

_____

City/Town_____ State: _____ Zip Code:_____

PLEASE INCLUDE A COPY OF THE MOST **RECENT INJECTION RECORD**.
PLEASE ALLOW A MINIMUM OF ***FOUR*** WEEKS FOR PREPERATION OF VIALS.
VIALS ARE NON-REFUNDABLE IF NOT PICKED UP OR ADMINISTERED AT ANOTHER FACILITY.

*** By filling out the information below you are agreeing to pay A.A.A.I.'s Annual shipping fee of $200 (if payment has not been previously made):**

Card Holders Name:_____ Credit Card Type:_____

Credit Card Number: _____-_____-_____-_____ Expiration Date:_____

***At the time of submitted this form, patient must include mailing address (if being mailed out), and the most recent copy of injection record.

*Any incomplete vial request form will not be processed or accepted.****

If choose to not pay the annual shipping fee you still have the option of picking up your vials here at the office.

Signature:_____ Date:_____