



Dr. Bear[®]'s Express Service Request Form



Organization: _____

Street Address: _____ Zip Code: _____ Ward: _____

Name/Title of person requesting service: _____

Telephone: _____ Fax: _____

Type of organization (check one):

- Licensed Day Care DC Public School Early Child Development Center
 Child Care Center Head Start Charter School
 Other _____

Age Range of Children (check all that apply):

- Infant – 1 year 2 years 3 years 4 years
 5-7 years 8-10 years 11-13 years <13 years

Service(s) Requested:

- Immunizations Healthcare Partnership Session

Date(s) requested: _____

Time(s) requested: _____

Signature: _____ Date: _____
Principal/Executive Director/Authorized Rep.

For Official Use Only

Date Received: _____ Service Date: _____

Date agency contacted: _____ Contacted by: _____

Confirmed: Yes No Pending _____

Please fax completed forms to (202) 675-5718. Forms must be received at least 14 business days prior to the date(s) requested. For further information, please call (202) 207-8990.