**Patient Write Off Approval Form**

**Date**

**Patient’s name**

**MRN**

**Date of service**

**Amount to write off**

**Reason**

**Type of vaccine (circle one)** VFC or Private Other

**Clinic (circle one)** Travel or Immunization

**Notes**

**APPROVALS**

Fiscal Manager Date

Director of Nursing or Designee Date

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I, acting as the president of the Board of Health and representing the Board of Health, authorize the above patient write off.

Board of Health President Date

***\*The Board of Health has to approve any requests over $125.00.***