

| Evaluated Immunization History and Immunization Forecast |   |      |      |                          |                          |
|--|---|------|------|--------------------------|--------------------------|
| <b>Test Case ID</b>                                      | Query the Registry for Juana Mariana Vazquez  |      |      |                          |                          |
| <b>Juror ID</b>  |   |      |      |                          |                          |
| <b>Juror Name</b>  |   |      |      |                          |                          |
| <b>HIT System Tested</b>                                 |   |      |      |                          |                          |
| <b>Inspection Date/Time</b>                              |   |      |      |                          |                          |
| <b>Inspection Settlement<br/>(Pass/Fail)</b>             | <table border="1"> <thead> <tr> <th>Pass</th> <th>Fail</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> | Pass | Fail | <input type="checkbox"/> | <input type="checkbox"/> |
| Pass   | Fail  |      |      |                          |                          |
| <input type="checkbox"/>                                 | <input type="checkbox"/>  |      |      |                          |                          |
| <b>Reason Failed</b>                                     |   |      |      |                          |                          |
| <b>Juror Comments</b>                                    |   |      |      |                          |                          |

## DISPLAY VERIFICATION

This Test Case-specific Juror Document provides a checklist for the Tester to use during certification testing for assessing the EHR technology's ability to display required core data elements from the information received in the Evaluated Immunization History and Immunization Forecast Z42 response message. Additional data from the message or from the EHR are permitted to be displayed by the EHR. Grayed-out fields in the Juror Document indicate where no data for the data element indicated were included in the Z42 message for the given Test Case.

The format of this Juror Document is for ease-of-use by the Tester and does not indicate how the EHR display must be designed.

The Evaluated Immunization History and Immunization Forecast data shown in this Juror Document are derived from the Z42 message provided with the given Test Case; equivalent data are permitted to be displayed by the EHR. The column headings are meant to convey the kind of data to be displayed; equivalent labels/column headings are permitted to be displayed by the EHR.

| Patient Information   |                       |                |
|---|-----------------------|----------------|
| Element Name  | Data                  | Tester Comment |
| <b>Patient Identifier</b>   |                       |                |
| <b>ID Number</b>  | 123456                |                |
| <b>Assigning Authority</b>  |                       |                |
| <b>Namespace ID</b>   | MYEHR                 |                |
| <b>ID Type</b>  | MR                    |                |
| <b>Patient Identifier</b>   |                       |                |
| <b>ID Number</b>  | 987633                |                |
| <b>Assigning Authority</b>  |                       |                |
| <b>Namespace ID</b>   | MYIIS                 |                |
| <b>ID Type</b>  | SR                    |                |
| <b>Name</b>   | Juana Mariana Vazquez |                |
| <b>Date of Birth</b>  | 11/01/2013            |                |
| <b>Sex</b>  | Female                |                |
| <b>Address 1</b>  |                       |                |
| <b>Street</b>   | 4345 Standish Way     |                |
| <b>Other Designation</b>  |                       |                |
| <b>City</b>   | Stamford              |                |
| <b>State</b>  | CT                    |                |
| <b>Zip Code</b>   | 06903                 |                |
| <b>Country</b>  | USA                   |                |
| <b>Address Type</b>   | L                     |                |
| <b>Mother's Maiden Name</b>   | Maria Merida Acosta   |                |
| <p>When displayed in the EHR with the Evaluated Immunization History and Immunization Forecast, these patient demographics data may be derived from either the received immunization message or the EHR patient record. When displaying demographics from the patient record, the EHR must be able to demonstrate a linkage between the demographics in the message (primarily the patient ID in PID-3.1) and the patient record used for display to ensure that the message was associated with the appropriate patient.</p> |                       |                |

| Evaluated Immunization History Information |   |                |
|--|---|----------------|
| Element Name                               | Data  | Tester Comment |
| <b>Entering Organization</b>               | Shoreline Hospital  |                |
| <b>Vaccine Group</b>                       | hepatitis B vaccine, unspecified formulation                  |                |
| <b>Vaccine Administered</b>                | hepatitis B vaccine, pediatric or pediatric/adolescent dosage |                |
| <b>Refusal Reason</b>                      |   |                |
| <b>Date/Time Administration-Start</b>      | 11/01/2013  |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Date/Time Administration-End               | 11/01/2013                                   |                |
| Administered Amount                        | 0.5  |                |
| Administered Units of Measure              | mL   |                |
| Route of Administration                    | Intramuscular                                |                |
| Administration Site                        | Left Thigh                                   |                |
| Substance Manufacturer Name                | GlaxoSmithKline Biologicals SA               |                |
| Administration Notes                       | new immunization record                      |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez                                   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC                                       |                |
| Street Address                             |  |                |
| Other Designation                          |  |                |
| City                                       |  |                |
| State                                      |  |                |
| Zip Code                                   |  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete                                     |                |
| Dose Number in Series                      | 1  |                |
| Number of Doses in Series                  | 3  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                         |                |
| Vaccine Group                              | hepatitis B vaccine, unspecified formulation |                |
| Vaccine Administered                       | hepatitis B vaccine, unspecified formulation |                |
| Refusal Reason                             |  |                |
| Date/Time Administration-Start             | 12/20/2013                                   |                |

| Evaluated Immunization History Information |   |                |
|--|---|----------------|
| Date/Time Administration-End               | 12/20/2013  |                |
| Administered Amount                        | 0.5   |                |
| Administered Units of Measure              | mL  |                |
| Route of Administration                    | Intramuscular   |                |
| Administration Site                        | Right Thigh   |                |
| Substance Manufacturer Name                | GlaxoSmithKline Biologicals SA                                |                |
| Administration Notes                       | new immunization record                                       |                |
| Administering Provider                     |   |                |
| Name                                       | J Martinez  |                |
| ID Number                                  |   |                |
| Administered-at Location                   |   |                |
| Facility ID                                | DCS_DC  |                |
| Street Address                             |   |                |
| Other Designation                          |   |                |
| City                                       |   |                |
| State                                      |   |                |
| Zip Code                                   |   |                |
| Country                                    |   |                |
| Valid Dose                                 | YES   |                |
| Validity Reason                            |   |                |
| Completion Status*                         | Complete  |                |
| Dose Number in Series                      | 2   |                |
| Number of Doses in Series                  | 3   |                |
| Immunization Series Name                   |   |                |
| Status in Immunization Series              |   |                |
| Immunization Schedule Used                 | ACIP  |                |
|  |   |                |
| Element Name                               | Data  | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics  |                |
| Vaccine Group                              | hepatitis B vaccine, unspecified formulation                  |                |
| Vaccine Administered                       | hepatitis B vaccine, pediatric or pediatric/adolescent dosage |                |
| Refusal Reason                             |   |                |
| Date/Time Administration-Start             | 05/20/2014  |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Date/Time Administration-End               | 05/20/2014   |                |
| Administered Amount                        | 0.5  |                |
| Administered Units of Measure              | mL   |                |
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Left Thigh   |                |
| Substance Manufacturer Name                | GlaxoSmithKline Biologicals SA   |                |
| Administration Notes                       | new immunization record  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             |  |                |
| Other Designation                          |  |                |
| City                                       |  |                |
| State                                      |  |                |
| Zip Code                                   |  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 3  |                |
| Number of Doses in Series                  | 3  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics   |                |
| Vaccine Group                              | diphtheria, tetanus toxoids and acellular pertussis vaccine, unspecified |                |
| Vaccine Administered                       | diphtheria, tetanus toxoids and acellular pertussis vaccine, unspecified |                |
| Refusal Reason                             |  |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Date/Time Administration-Start             | 01/22/2014   |                |
| Date/Time Administration-End               | 01/22/2014   |                |
| Administered Amount                        | 0.5  |                |
| Administered Units of Measure              | mL   |                |
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Left Thigh   |                |
| Substance Manufacturer Name                | Sanofi Pasteur Inc   |                |
| Administration Notes                       | new immunization record  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             |  |                |
| Other Designation                          |  |                |
| City                                       |  |                |
| State                                      |  |                |
| Zip Code                                   |  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 1  |                |
| Number of Doses in Series                  | 5  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics   |                |
| Vaccine Group                              | diphtheria, tetanus toxoids and acellular pertussis vaccine, unspecified |                |
| Vaccine Administered                       | diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis |                |
| Refusal Reason                             |  |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Date/Time Administration-Start             | 03/23/2014   |                |
| Date/Time Administration-End               | 03/23/2014   |                |
| Administered Amount                        | 0.5  |                |
| Administered Units of Measure              | mL   |                |
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Right Thigh  |                |
| Substance Manufacturer Name                | Sanofi Pasteur Inc   |                |
| Administration Notes                       | new immunization record  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             |  |                |
| Other Designation                          |  |                |
| City                                       |  |                |
| State                                      |  |                |
| Zip Code                                   |  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 2  |                |
| Number of Doses in Series                  | 5  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics   |                |
| Vaccine Group                              | diphtheria, tetanus toxoids and acellular pertussis vaccine, unspecified |                |
| Vaccine Administered                       | diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis |                |
| Refusal Reason                             |  |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Date/Time Administration-Start             | 05/22/2014   |                |
| Date/Time Administration-End               | 05/22/2014   |                |
| Administered Amount                        | 0.5  |                |
| Administered Units of Measure              | mL   |                |
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Left Thigh   |                |
| Substance Manufacturer Name                | Sanofi Pasteur Inc   |                |
| Administration Notes                       | new immunization record  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             |  |                |
| Other Designation                          |  |                |
| City                                       |  |                |
| State                                      |  |                |
| Zip Code                                   |  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 3  |                |
| Number of Doses in Series                  | 5  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics   |                |
| Vaccine Group                              | diphtheria, tetanus toxoids and acellular pertussis vaccine, unspecified |                |
| Vaccine Administered                       | diphtheria, tetanus toxoids and acellular pertussis vaccine, 5 pertussis |                |
| Refusal Reason                             |  |                |



| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Date/Time Administration-Start             | 02/21/2015   |                |
| Date/Time Administration-End               | 02/21/2015   |                |
| Administered Amount                        | 0.5  |                |
| Administered Units of Measure              | mL   |                |
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Left Deltoid   |                |
| Substance Manufacturer Name                | Sanofi Pasteur Inc                                       |                |
| Administration Notes                       | new immunization record                                  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             |  |                |
| Other Designation                          |  |                |
| City                                       |  |                |
| State                                      |  |                |
| Zip Code                                   |  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 4  |                |
| Number of Doses in Series                  | 5  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                                     |                |
| Vaccine Group                              | Hib, unspecified formulation                             |                |
| Vaccine Administered                       | Haemophilus influenzae type b vaccine, PRP-OMP conjugate |                |
| Refusal Reason                             |  |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Date/Time Administration-Start             | 01/22/2014   |                |
| Date/Time Administration-End               | 01/22/2014   |                |
| Administered Amount                        | 0.5  |                |
| Administered Units of Measure              | mL   |                |
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Right Thigh  |                |
| Substance Manufacturer Name                | Merck Sharp and Dohme Corp                               |                |
| Administration Notes                       | new immunization record                                  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             |  |                |
| Other Designation                          |  |                |
| City                                       |  |                |
| State                                      |  |                |
| Zip Code                                   |  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 1  |                |
| Number of Doses in Series                  | 4  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                                     |                |
| Vaccine Group                              | Hib, unspecified formulation                             |                |
| Vaccine Administered                       | Haemophilus influenzae type b vaccine, PRP-OMP conjugate |                |
| Refusal Reason                             |  |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Date/Time Administration-Start             | 03/23/2014   |                |
| Date/Time Administration-End               | 03/23/2014   |                |
| Administered Amount                        | 0.5  |                |
| Administered Units of Measure              | mL   |                |
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Left Thigh   |                |
| Substance Manufacturer Name                | Merck Sharp and Dohme Corp                               |                |
| Administration Notes                       | new immunization record                                  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             | 333 Oceanview Lane                                       |                |
| Other Designation                          |  |                |
| City                                       | Stamford   |                |
| State                                      | CT   |                |
| Zip Code                                   | 06901  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 2  |                |
| Number of Doses in Series                  | 4  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                                     |                |
| Vaccine Group                              | Hib, unspecified formulation                             |                |
| Vaccine Administered                       | Haemophilus influenzae type b vaccine, PRP-OMP conjugate |                |
| Refusal Reason                             |  |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Date/Time Administration-Start             | 05/22/2014   |                |
| Date/Time Administration-End               | 05/22/2014   |                |
| Administered Amount                        | 0.5  |                |
| Administered Units of Measure              | mL   |                |
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Right Thigh  |                |
| Substance Manufacturer Name                | Merck Sharp and Dohme Corp                               |                |
| Administration Notes                       | new immunization record                                  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             | 333 Oceanview Lane                                       |                |
| Other Designation                          |  |                |
| City                                       | Stamford   |                |
| State                                      | CT   |                |
| Zip Code                                   | 06901  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 3  |                |
| Number of Doses in Series                  | 4  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                                     |                |
| Vaccine Group                              | Hib, unspecified formulation                             |                |
| Vaccine Administered                       | Haemophilus influenzae type b vaccine, PRP-OMP conjugate |                |
| Refusal Reason                             |  |                |

| Evaluated Immunization History Information |                                 |                |
|--|---------------------------------|----------------|
| Date/Time Administration-Start             | 11/21/2014                      |                |
| Date/Time Administration-End               | 11/21/2014                      |                |
| Administered Amount                        | 0.5                             |                |
| Administered Units of Measure              | mL                              |                |
| Route of Administration                    | Intramuscular                   |                |
| Administration Site                        | Left Deltoid                    |                |
| Substance Manufacturer Name                | Merck Sharp and Dohme Corp      |                |
| Administration Notes                       | new immunization record         |                |
| Administering Provider                     |                                 |                |
| Name                                       | J Martinez                      |                |
| ID Number                                  |                                 |                |
| Administered-at Location                   |                                 |                |
| Facility ID                                | DCS_DC                          |                |
| Street Address                             | 333 Oceanview Lane              |                |
| Other Designation                          |                                 |                |
| City                                       | Stamford                        |                |
| State                                      | CT                              |                |
| Zip Code                                   | 06901                           |                |
| Country                                    |                                 |                |
| Valid Dose                                 | YES                             |                |
| Validity Reason                            |                                 |                |
| Completion Status*                         | Complete                        |                |
| Dose Number in Series                      | 4                               |                |
| Number of Doses in Series                  | 4                               |                |
| Immunization Series Name                   |                                 |                |
| Status in Immunization Series              |                                 |                |
| Immunization Schedule Used                 | ACIP                            |                |
|  |                                 |                |
| Element Name                               | Data                            | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics            |                |
| Vaccine Group                              | poliovirus vaccine, inactivated |                |
| Vaccine Administered                       | poliovirus vaccine, inactivated |                |
| Refusal Reason                             |                                 |                |
| Date/Time Administration-Start             | 01/22/2014                      |                |

| Evaluated Immunization History Information |                                 |                |
|--|---------------------------------|----------------|
| Date/Time Administration-End               | 01/22/2014                      |                |
| Administered Amount                        | 0.5                             |                |
| Administered Units of Measure              | mL                              |                |
| Route of Administration                    | Subcutaneous                    |                |
| Administration Site                        | Left Deltoid                    |                |
| Substance Manufacturer Name                | Sanofi Pasteur Inc              |                |
| Administration Notes                       | new immunization record         |                |
| Administering Provider                     |                                 |                |
| Name                                       | J Martinez                      |                |
| ID Number                                  |                                 |                |
| Administered-at Location                   |                                 |                |
| Facility ID                                | DCS_DC                          |                |
| Street Address                             | 333 Oceanview Lane              |                |
| Other Designation                          |                                 |                |
| City                                       | Stamford                        |                |
| State                                      | CT                              |                |
| Zip Code                                   | 06901                           |                |
| Country                                    |                                 |                |
| Valid Dose                                 | YES                             |                |
| Validity Reason                            |                                 |                |
| Completion Status*                         | Complete                        |                |
| Dose Number in Series                      | 1                               |                |
| Number of Doses in Series                  | 4                               |                |
| Immunization Series Name                   |                                 |                |
| Status in Immunization Series              |                                 |                |
| Immunization Schedule Used                 | ACIP                            |                |
|  |                                 |                |
| Element Name                               | Data                            | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics            |                |
| Vaccine Group                              | poliovirus vaccine, inactivated |                |
| Vaccine Administered                       | poliovirus vaccine, inactivated |                |
| Refusal Reason                             |                                 |                |
| Date/Time Administration-Start             | 03/23/2014                      |                |
| Date/Time Administration-End               | 03/23/2014                      |                |

| Evaluated Immunization History Information |   |                |
|--|---|----------------|
| Administered Amount                        | 0.5                                       |                |
| Administered Units of Measure              | mL  |                |
| Route of Administration                    | Subcutaneous                              |                |
| Administration Site                        | Left Deltoid                              |                |
| Substance Manufacturer Name                | Sanofi Pasteur Inc                        |                |
| Administration Notes                       | new immunization record                   |                |
| Administering Provider                     |   |                |
| Name                                       | J Martinez                                |                |
| ID Number                                  |   |                |
| Administered-at Location                   |   |                |
| Facility ID                                | DCS_DC                                    |                |
| Street Address                             | 333 Oceanview Lane                        |                |
| Other Designation                          |   |                |
| City                                       | Stamford                                  |                |
| State                                      | CT  |                |
| Zip Code                                   | 06901                                     |                |
| Country                                    |   |                |
| Valid Dose                                 | YES                                       |                |
| Validity Reason                            |   |                |
| Completion Status*                         | Complete                                  |                |
| Dose Number in Series                      | 2   |                |
| Number of Doses in Series                  | 4   |                |
| Immunization Series Name                   |   |                |
| Status in Immunization Series              |   |                |
| Immunization Schedule Used                 | ACIP                                      |                |
|  |   |                |
| Element Name                               | Data                                      | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                      |                |
| Vaccine Group                              | pneumococcal, unspecified formulation     |                |
| Vaccine Administered                       | pneumococcal conjugate vaccine, 13 valent |                |
| Refusal Reason                             |   |                |
| Date/Time Administration-Start             | 01/22/2014                                |                |
| Date/Time Administration-End               | 01/22/2014                                |                |

| Evaluated Immunization History Information |   |                |
|--|---|----------------|
| Administered Amount                        | 0.5                                       |                |
| Administered Units of Measure              | mL  |                |
| Route of Administration                    | Intramuscular                             |                |
| Administration Site                        | Left Thigh                                |                |
| Substance Manufacturer Name                | Pfizer, Inc                               |                |
| Administration Notes                       | new immunization record                   |                |
| Administering Provider                     |   |                |
| Name                                       | J Martinez                                |                |
| ID Number                                  |   |                |
| Administered-at Location                   |   |                |
| Facility ID                                | DCS_DC                                    |                |
| Street Address                             | 333 Oceanview Lane                        |                |
| Other Designation                          |   |                |
| City                                       | Stamford                                  |                |
| State                                      | CT  |                |
| Zip Code                                   | 06901                                     |                |
| Country                                    |   |                |
| Valid Dose                                 | YES                                       |                |
| Validity Reason                            |   |                |
| Completion Status*                         | Complete                                  |                |
| Dose Number in Series                      | 1   |                |
| Number of Doses in Series                  | 4   |                |
| Immunization Series Name                   |   |                |
| Status in Immunization Series              |   |                |
| Immunization Schedule Used                 | ACIP                                      |                |
|  |   |                |
| Element Name                               | Data                                      | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                      |                |
| Vaccine Group                              | pneumococcal, unspecified formulation     |                |
| Vaccine Administered                       | pneumococcal conjugate vaccine, 13 valent |                |
| Refusal Reason                             |   |                |
| Date/Time Administration-Start             | 03/23/2014                                |                |
| Date/Time Administration-End               | 03/23/2014                                |                |



| Evaluated Immunization History Information |   |                |
|--|---|----------------|
| Administered Amount                        | 0.5                                       |                |
| Administered Units of Measure              | mL  |                |
| Route of Administration                    | Intramuscular                             |                |
| Administration Site                        | Left Thigh                                |                |
| Substance Manufacturer Name                | Pfizer, Inc                               |                |
| Administration Notes                       | new immunization record                   |                |
| Administering Provider                     |   |                |
| Name                                       | J Martinez                                |                |
| ID Number                                  |   |                |
| Administered-at Location                   |   |                |
| Facility ID                                | DCS_DC                                    |                |
| Street Address                             | 333 Oceanview Lane                        |                |
| Other Designation                          |   |                |
| City                                       | Stamford                                  |                |
| State                                      | CT  |                |
| Zip Code                                   | 06901                                     |                |
| Country                                    |   |                |
| Valid Dose                                 | YES                                       |                |
| Validity Reason                            |   |                |
| Completion Status*                         | Complete                                  |                |
| Dose Number in Series                      | 2   |                |
| Number of Doses in Series                  | 4   |                |
| Immunization Series Name                   |   |                |
| Status in Immunization Series              |   |                |
| Immunization Schedule Used                 | ACIP                                      |                |
|  |   |                |
| Element Name                               | Data                                      | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                      |                |
| Vaccine Group                              | pneumococcal, unspecified formulation     |                |
| Vaccine Administered                       | pneumococcal conjugate vaccine, 13 valent |                |
| Refusal Reason                             |   |                |
| Date/Time Administration-Start             | 05/22/2014                                |                |
| Date/Time Administration-End               | 05/22/2014                                |                |

| Evaluated Immunization History Information |   |                |
|--|---|----------------|
| Administered Amount                        | 0.5                                       |                |
| Administered Units of Measure              | mL  |                |
| Route of Administration                    | Intramuscular                             |                |
| Administration Site                        | Right Thigh                               |                |
| Substance Manufacturer Name                | Pfizer, Inc                               |                |
| Administration Notes                       | new immunization record                   |                |
| Administering Provider                     |   |                |
| Name                                       | J Martinez                                |                |
| ID Number                                  |   |                |
| Administered-at Location                   |   |                |
| Facility ID                                | DCS_DC                                    |                |
| Street Address                             | 333 Oceanview Lane                        |                |
| Other Designation                          |   |                |
| City                                       | Stamford                                  |                |
| State                                      | CT  |                |
| Zip Code                                   | 06901                                     |                |
| Country                                    |   |                |
| Valid Dose                                 | YES                                       |                |
| Validity Reason                            |   |                |
| Completion Status*                         | Complete                                  |                |
| Dose Number in Series                      | 3   |                |
| Number of Doses in Series                  | 4   |                |
| Immunization Series Name                   |   |                |
| Status in Immunization Series              |   |                |
| Immunization Schedule Used                 | ACIP                                      |                |
|  |   |                |
| Element Name                               | Data                                      | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                      |                |
| Vaccine Group                              | pneumococcal, unspecified formulation     |                |
| Vaccine Administered                       | pneumococcal conjugate vaccine, 13 valent |                |
| Refusal Reason                             |   |                |
| Date/Time Administration-Start             | 01/11/2015                                |                |
| Date/Time Administration-End               | 01/11/2015                                |                |

| Evaluated Immunization History Information |                                     |                |
|--|-------------------------------------|----------------|
| Administered Amount                        | 0.5                                 |                |
| Administered Units of Measure              | mL                                  |                |
| Route of Administration                    | Intramuscular                       |                |
| Administration Site                        | Left Deltoid                        |                |
| Substance Manufacturer Name                | Pfizer, Inc                         |                |
| Administration Notes                       | new immunization record             |                |
| Administering Provider                     |                                     |                |
| Name                                       | J Martinez                          |                |
| ID Number                                  |                                     |                |
| Administered-at Location                   |                                     |                |
| Facility ID                                | DCS_DC                              |                |
| Street Address                             | 333 Oceanview Lane                  |                |
| Other Designation                          |                                     |                |
| City                                       | Stamford                            |                |
| State                                      | CT                                  |                |
| Zip Code                                   | 06901                               |                |
| Country                                    |                                     |                |
| Valid Dose                                 | YES                                 |                |
| Validity Reason                            |                                     |                |
| Completion Status*                         | Complete                            |                |
| Dose Number in Series                      | 4                                   |                |
| Number of Doses in Series                  | 4                                   |                |
| Immunization Series Name                   |                                     |                |
| Status in Immunization Series              |                                     |                |
| Immunization Schedule Used                 | ACIP                                |                |
|  |                                     |                |
| Element Name                               | Data                                | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                |                |
| Vaccine Group                              | rotavirus, unspecified formulation  |                |
| Vaccine Administered                       | rotavirus, live, monovalent vaccine |                |
| Refusal Reason                             |                                     |                |
| Date/Time Administration-Start             | 01/22/2014                          |                |
| Date/Time Administration-End               | 01/22/2014                          |                |
| Administered Amount                        | 0.5                                 |                |

| Evaluated Immunization History Information |                                     |                |
|--|-------------------------------------|----------------|
| Administered Units of Measure              | mL                                  |                |
| Route of Administration                    | Oral                                |                |
| Administration Site                        | Left Thigh                          |                |
| Substance Manufacturer Name                | GlaxoSmithKline Biologicals SA      |                |
| Administration Notes                       | new immunization record             |                |
| Administering Provider                     |                                     |                |
| Name                                       | J Martinez                          |                |
| ID Number                                  |                                     |                |
| Administered-at Location                   |                                     |                |
| Facility ID                                | DCS_DC                              |                |
| Street Address                             | 333 Oceanview Lane                  |                |
| Other Designation                          |                                     |                |
| City                                       | Stamford                            |                |
| State                                      | CT                                  |                |
| Zip Code                                   | 06901                               |                |
| Country                                    |                                     |                |
| Valid Dose                                 | YES                                 |                |
| Validity Reason                            |                                     |                |
| Completion Status*                         | Complete                            |                |
| Dose Number in Series                      | 1                                   |                |
| Number of Doses in Series                  | 3                                   |                |
| Immunization Series Name                   |                                     |                |
| Status in Immunization Series              |                                     |                |
| Immunization Schedule Used                 | ACIP                                |                |
|  |                                     |                |
| Element Name                               | Data                                | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                |                |
| Vaccine Group                              | rotavirus, unspecified formulation  |                |
| Vaccine Administered                       | rotavirus, live, monovalent vaccine |                |
| Refusal Reason                             |                                     |                |
| Date/Time Administration-Start             | 03/23/2014                          |                |
| Date/Time Administration-End               | 03/23/2014                          |                |
| Administered Amount                        | 0.5                                 |                |
| Administered Units of Measure              | mL                                  |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Route of Administration                    | Oral   |                |
| Administration Site                        | Right Thigh  |                |
| Substance Manufacturer Name                | GlaxoSmithKline Biologicals SA                                   |                |
| Administration Notes                       | new immunization record  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             | 333 Oceanview Lane   |                |
| Other Designation                          |  |                |
| City                                       | Stamford   |                |
| State                                      | CT   |                |
| Zip Code                                   | 06901  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 2  |                |
| Number of Doses in Series                  | 3  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics   |                |
| Vaccine Group                              | influenza, unspecified formulation                               |                |
| Vaccine Administered                       | Influenza, injectable,quadrivalent, preservative free, pediatric |                |
| Refusal Reason                             |  |                |
| Date/Time Administration-Start             | 09/25/2014   |                |
| Date/Time Administration-End               | 09/25/2014   |                |
| Administered Amount                        | 0.25   |                |
| Administered Units of Measure              | mL   |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Left Thigh   |                |
| Substance Manufacturer Name                | Sanofi Pasteur   |                |
| Administration Notes                       | new immunization record  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             | 333 Oceanview Lane   |                |
| Other Designation                          |  |                |
| City                                       | Stamford   |                |
| State                                      | CT   |                |
| Zip Code                                   | 06901  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 1  |                |
| Number of Doses in Series                  | 2  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics   |                |
| Vaccine Group                              | influenza, unspecified formulation                               |                |
| Vaccine Administered                       | Influenza, injectable,quadrivalent, preservative free, pediatric |                |
| Refusal Reason                             |  |                |
| Date/Time Administration-Start             | 10/29/2014   |                |
| Date/Time Administration-End               | 10/29/2014   |                |
| Administered Amount                        | 0.25   |                |
| Administered Units of Measure              | mL   |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Right Thigh  |                |
| Substance Manufacturer Name                | Sanofi Pasteur   |                |
| Administration Notes                       | new immunization record  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             | 333 Oceanview Lane   |                |
| Other Designation                          |  |                |
| City                                       | Stamford   |                |
| State                                      | CT   |                |
| Zip Code                                   | 06901  |                |
| Country                                    |  |                |
| Valid Dose                                 | YES  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      | 2  |                |
| Number of Doses in Series                  | 2  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics   |                |
| Vaccine Group                              | influenza, unspecified formulation                               |                |
| Vaccine Administered                       | Influenza, injectable,quadrivalent, preservative free, pediatric |                |
| Refusal Reason                             |  |                |
| Date/Time Administration-Start             | 10/02/2015   |                |
| Date/Time Administration-End               | 10/02/2015   |                |
| Administered Amount                        | .25  |                |
| Administered Units of Measure              | mL   |                |

| Evaluated Immunization History Information |  |                |
|--|--|----------------|
| Route of Administration                    | Intramuscular  |                |
| Administration Site                        | Left Deltoid   |                |
| Substance Manufacturer Name                | Sanofi Pasteur   |                |
| Administration Notes                       | new immunization record  |                |
| Administering Provider                     |  |                |
| Name                                       | J Martinez   |                |
| ID Number                                  |  |                |
| Administered-at Location                   |  |                |
| Facility ID                                | DCS_DC   |                |
| Street Address                             | 333 Oceanview Lane   |                |
| Other Designation                          |  |                |
| City                                       | Stamford   |                |
| State                                      | CT   |                |
| Zip Code                                   | 06901  |                |
| Country                                    |  |                |
| Valid Dose                                 |  |                |
| Validity Reason                            |  |                |
| Completion Status*                         | Complete   |                |
| Dose Number in Series                      |  |                |
| Number of Doses in Series                  |  |                |
| Immunization Series Name                   |  |                |
| Status in Immunization Series              |  |                |
| Immunization Schedule Used                 | ACIP   |                |
|  |  |                |
| Element Name                               | Data   | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics   |                |
| Vaccine Group                              | influenza, unspecified formulation                               |                |
| Vaccine Administered                       | Influenza, injectable,quadrivalent, preservative free, pediatric |                |
| Refusal Reason                             |  |                |
| Date/Time Administration-Start             | 11/04/2016   |                |
| Date/Time Administration-End               | 11/04/2016   |                |
| Administered Amount                        | 0.25   |                |
| Administered Units of Measure              | mL   |                |



| Evaluated Immunization History Information |   |                |
|--|---|----------------|
| Route of Administration                    | Intramuscular   |                |
| Administration Site                        | Left Deltoid  |                |
| Substance Manufacturer Name                | Sanofi Pasteur  |                |
| Administration Notes                       | new immunization record   |                |
| Administering Provider                     |   |                |
| Name                                       | J Martinez  |                |
| ID Number                                  |   |                |
| Administered-at Location                   |   |                |
| Facility ID                                | DCS_DC  |                |
| Street Address                             | 333 Oceanview Lane  |                |
| Other Designation                          |   |                |
| City                                       | Stamford  |                |
| State                                      | CT  |                |
| Zip Code                                   | 06901   |                |
| Country                                    |   |                |
| Valid Dose                                 |   |                |
| Validity Reason                            |   |                |
| Completion Status*                         | Complete  |                |
| Dose Number in Series                      |   |                |
| Number of Doses in Series                  |   |                |
| Immunization Series Name                   |   |                |
| Status in Immunization Series              |   |                |
| Immunization Schedule Used                 | ACIP  |                |
|  |   |                |
| Element Name                               | Data  | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics  |                |
| Vaccine Group                              | Hep A, unspecified formulation                                    |                |
| Vaccine Administered                       | hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule |                |
| Refusal Reason                             |   |                |
| Date/Time Administration-Start             | 11/23/2014  |                |
| Date/Time Administration-End               | 11/23/2014  |                |
| Administered Amount                        | 0.5   |                |
| Administered Units of Measure              | mL  |                |

| Evaluated Immunization History Information |   |                |
|--|---|----------------|
| Route of Administration                    | Intramuscular   |                |
| Administration Site                        | Right Deltoid   |                |
| Substance Manufacturer Name                | GlaxoSmithKline Biologicals SA                                    |                |
| Administration Notes                       | new immunization record   |                |
| Administering Provider                     |   |                |
| Name                                       | J Martinez  |                |
| ID Number                                  |   |                |
| Administered-at Location                   |   |                |
| Facility ID                                | DCS_DC  |                |
| Street Address                             | 333 Oceanview Lane  |                |
| Other Designation                          |   |                |
| City                                       | Stamford  |                |
| State                                      | CT  |                |
| Zip Code                                   | 06901   |                |
| Country                                    |   |                |
| Valid Dose                                 |   |                |
| Validity Reason                            |   |                |
| Completion Status*                         | Complete  |                |
| Dose Number in Series                      | 1   |                |
| Number of Doses in Series                  | 2   |                |
| Immunization Series Name                   |   |                |
| Status in Immunization Series              |   |                |
| Immunization Schedule Used                 | ACIP  |                |
|  |   |                |
| Element Name                               | Data  | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics  |                |
| Vaccine Group                              | Hep A, unspecified formulation                                    |                |
| Vaccine Administered                       | hepatitis A vaccine, pediatric/adolescent dosage, 2 dose schedule |                |
| Refusal Reason                             |   |                |
| Date/Time Administration-Start             | 05/23/2015  |                |
| Date/Time Administration-End               | 05/23/2015  |                |
| Administered Amount                        | 0.5   |                |
| Administered Units of Measure              | mL  |                |

| Evaluated Immunization History Information |                                       |                |
|--|---------------------------------------|----------------|
| Route of Administration                    | Intramuscular                         |                |
| Administration Site                        | Left Deltoid                          |                |
| Substance Manufacturer Name                | GlaxoSmithKline Biologicals SA        |                |
| Administration Notes                       | new immunization record               |                |
| Administering Provider                     |                                       |                |
| Name                                       | J Martinez                            |                |
| ID Number                                  |                                       |                |
| Administered-at Location                   |                                       |                |
| Facility ID                                | DCS_DC                                |                |
| Street Address                             | 333 Oceanview Lane                    |                |
| Other Designation                          |                                       |                |
| City                                       | Stamford                              |                |
| State                                      | CT                                    |                |
| Zip Code                                   | 06901                                 |                |
| Country                                    |                                       |                |
| Valid Dose                                 |                                       |                |
| Validity Reason                            |                                       |                |
| Completion Status*                         | Complete                              |                |
| Dose Number in Series                      | 2                                     |                |
| Number of Doses in Series                  | 2                                     |                |
| Immunization Series Name                   |                                       |                |
| Status in Immunization Series              |                                       |                |
| Immunization Schedule Used                 | ACIP                                  |                |
|  |                                       |                |
| Element Name                               | Data                                  | Tester Comment |
| Entering Organization                      | Shoreline Pediatrics                  |                |
| Vaccine Group                              | MMR                                   |                |
| Vaccine Administered                       | measles, mumps, rubella virus vaccine |                |
| Refusal Reason                             |                                       |                |
| Date/Time Administration-Start             | 08/22/2014                            |                |
| Date/Time Administration-End               | 08/22/2014                            |                |
| Administered Amount                        | 0.5                                   |                |
| Administered Units of Measure              | mL                                    |                |
| Route of Administration                    | Subcutaneous                          |                |

| Evaluated Immunization History Information |                                       |                |
|--|---------------------------------------|----------------|
| Administration Site                        | Left Thigh                            |                |
| Substance Manufacturer Name                | Merck Sharp and Dohme Corp            |                |
| Administration Notes                       | new immunization record               |                |
| Administering Provider                     |                                       |                |
| Name                                       | Sandra Molina                         |                |
| ID Number                                  |                                       |                |
| Administered-at Location                   |                                       |                |
| Facility ID                                | DCS_DC                                |                |
| Street Address                             | 400 Shoreline Drive                   |                |
| Other Designation                          |                                       |                |
| City                                       | Stamford                              |                |
| State                                      | CT                                    |                |
| Zip Code                                   | 06901                                 |                |
| Country                                    |                                       |                |
| Valid Dose                                 | NO                                    |                |
| Validity Reason                            | Early                                 |                |
| Completion Status*                         | Complete                              |                |
| Dose Number in Series                      |                                       |                |
| Number of Doses in Series                  |                                       |                |
| Immunization Series Name                   |                                       |                |
| Status in Immunization Series              |                                       |                |
| Immunization Schedule Used                 | ACIP                                  |                |
|  |                                       |                |
| Element Name                               | Data                                  | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics                  |                |
| Vaccine Group                              | MMR                                   |                |
| Vaccine Administered                       | measles, mumps, rubella virus vaccine |                |
| Refusal Reason                             |                                       |                |
| Date/Time Administration-Start             | 11/22/2017                            |                |
| Date/Time Administration-End               | 11/22/2017                            |                |
| Administered Amount                        | 0.5                                   |                |
| Administered Units of Measure              | mL                                    |                |
| Route of Administration                    | Subcutaneous                          |                |
| Administration Site                        | Left Deltoid                          |                |

| Evaluated Immunization History Information |                            |                |
|--|----------------------------|----------------|
| Substance Manufacturer Name                | Merck Sharp and Dohme Corp |                |
| Administration Notes                       | new immunization record    |                |
| Administering Provider                     |                            |                |
| Name                                       | J Martinez                 |                |
| ID Number                                  |                            |                |
| Administered-at Location                   |                            |                |
| Facility ID                                | DCS_DC                     |                |
| Street Address                             | 333 Oceanview Lane         |                |
| Other Designation                          |                            |                |
| City                                       | Stamford                   |                |
| State                                      | CT                         |                |
| Zip Code                                   | 06901                      |                |
| Country                                    |                            |                |
| Valid Dose                                 | YES                        |                |
| Validity Reason                            |                            |                |
| Completion Status*                         | Complete                   |                |
| Dose Number in Series                      | 1                          |                |
| Number of Doses in Series                  | 2                          |                |
| Immunization Series Name                   |                            |                |
| Status in Immunization Series              |                            |                |
| Immunization Schedule Used                 | ACIP                       |                |
|  |                            |                |
| Element Name                               | Data                       | Tester Comment |
| Entering Organization                      | Oceanview Pediatrics       |                |
| Vaccine Group                              | Varicella virus vaccine    |                |
| Vaccine Administered                       | varicella virus vaccine    |                |
| Refusal Reason                             |                            |                |
| Date/Time Administration-Start             | 12/15/2015                 |                |
| Date/Time Administration-End               | 12/15/2015                 |                |
| Administered Amount                        | 0.5                        |                |
| Administered Units of Measure              | mL                         |                |
| Route of Administration                    | Subcutaneous               |                |
| Administration Site                        | Right Deltoid              |                |
| Substance Manufacturer Name                | Merck Sharp and Dohme Corp |                |

| Evaluated Immunization History Information  |                         |  |
|---|-------------------------|--|
| Administration Notes  | new immunization record |  |
| Administering Provider  |                         |  |
| Name  | J Martinez              |  |
| ID Number   |                         |  |
| Administered-at Location  |                         |  |
| Facility ID   | DCS_DC                  |  |
| Street Address  | 333 Oceanview Lane      |  |
| Other Designation   |                         |  |
| City  | Stamford                |  |
| State   | CT                      |  |
| Zip Code  | 06901                   |  |
| Country   |                         |  |
| Valid Dose  | YES                     |  |
| Validity Reason   |                         |  |
| Completion Status*  | Complete                |  |
| Dose Number in Series   | 1                       |  |
| Number of Doses in Series   | 2                       |  |
| Immunization Series Name  |                         |  |
| Status in Immunization Series   |                         |  |
| Immunization Schedule Used  | ACIP                    |  |
| <p>* "Completion Status" refers to the status of the dose of vaccine administered on the indicated date and may be interpreted as "Dose Status". A status of "Complete" means that the vaccine dose was "completely administered" as opposed to "partially administered".</p> |                         |  |

| Immunization Forecast         |                                    |                |
|-------------------------------|------------------------------------|----------------|
| Element Name                  | Data                               | Tester Comment |
| Vaccine Group                 | IPV                                |                |
| Vaccine Due Date              | 04/29/2014                         |                |
| Earliest Date to Give         | 04/29/2014                         |                |
| Latest Date to Give           |                                    |                |
| Date When Vaccine Overdue     | 04/30/2015                         |                |
| Status in Immunization Series |                                    |                |
| Forecast Reason               |                                    |                |
| Element Name                  | Data                               | Tester Comment |
| Vaccine Group                 | influenza, unspecified formulation |                |
| Vaccine Due Date              | 09/01/2018                         |                |
| Earliest Date to Give         | 09/01/2018                         |                |
| Latest Date to Give           |                                    |                |
| Date When Vaccine Overdue     | 10/31/2019                         |                |
| Status in Immunization Series |                                    |                |
| Forecast Reason               |                                    |                |
| Element Name                  | Data                               | Tester Comment |
| Vaccine Group                 | MMR                                |                |
| Vaccine Due Date              | 10/31/2017                         |                |
| Earliest Date to Give         | 10/31/2017                         |                |
| Latest Date to Give           |                                    |                |
| Date When Vaccine Overdue     | 10/31/2019                         |                |
| Status in Immunization Series |                                    |                |
| Forecast Reason               |                                    |                |
| Element Name                  | Data                               | Tester Comment |
| Vaccine Group                 | Varicella                          |                |
| Vaccine Due Date              | 10/31/2017                         |                |
| Earliest Date to Give         | 10/31/2017                         |                |
| Latest Date to Give           |                                    |                |
| Date When Vaccine Overdue     | 10/31/2019                         |                |
| Status in Immunization Series |                                    |                |
| Forecast Reason               |                                    |                |