



# Petition for Modification Form – Immunization Correction

Return completed forms to the MCIR Help Desk

[MDHHS-MCIRHelp@michigan.gov](mailto:MDHHS-MCIRHelp@michigan.gov) (encrypt emails) or 517-763-0370

Providers should only request modification to immunization data for immunizations NOT entered by their office. Immunizations entered by your office can be [modified by you](#) and **do not** require this form.

If the data is **underlined** in the history screen, you can modify the immunization data:

<u>Influenza ccIV4 (Flucelvax Quad P-Free, Inj)</u>	9 29 Years 3 Months	11/10/2023	Test Provider 123	Seqirus	370661	<u>Delete</u>
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Immunization data that is **not underlined** was entered by other health care providers and **cannot be modified by you**.

Influenza IIV4 (P-Free Inj)	8 28 Years 1 Month	09/13/2022	Test Provider ABC	Glaxo	CB7Z4
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### Form Instructions

- **Complete the REQUIRED Sections 1-3.** Be as specific as possible when listing the Current and Correct Vaccine information – write exactly what is listed in MCIR under Vaccine Name.
  - **Acceptable:** DTaP-Hib-IPV *OR* Pentacel, COVID-19 Pfizer Bivalent, PCV13, Shingrix, HPV4
  - **Unacceptable:** COVID, Influenza/Flu, Pneumonia, Shingles, HPV, or phrases such as “See Attached”
- **Attach a REQUIRED copy of documentation/shot record to support the changes.**
  - **Exception:** The only exception is for duplicate shot dates for the same vaccine. Enter “Duplicate” in the Correct Date field in Section 3. Documentation is not required ONLY for duplicate deletions.
- **Attach additional sheets if needed for additional modifications/deletions.**

Failure to complete ALL Sections 1-4 OR to submit REQUIRED documentation will delay processing of this request.

SECTION 1 - Requestor’s Information (REQUIRED)					
Organization Name OR MCIR Site ID Number*		Email Address*		<b>DOCUMENTATION ATTACHED?</b> <input type="checkbox"/> YES – Documentation/shot record is included with this form. <input type="checkbox"/> NO – This form is ONLY for a duplicate date request.	
Full Name - Person Completing Form*		Phone Number*			
		(    )	Ext:		
SECTION 2 - Person Information (REQUIRED)					
Last Name	First Name	Middle Name	Date of Birth	MCIR ID	
SECTION 3 - Immunization Information (REQUIRED)					
Current Vaccine (as shown in MCIR)	Current Date (mm/dd/yy)	Correct Vaccine (if applicable)	Correct Date (mm/dd/yy)	Check Below	
				Modify	Delete
SECTION 4 – SIGNATURE (REQUIRED FOR ALL REQUESTS)					
By signing below, I verify that I have retained legal documentation to support the changes requested above.					
Signature*:				Date*:	