

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]

[Recipient Name]
[Recipient Title/Position]
[Organization Name]
[Organization Address]
[City, State, Zip Code]

Dear [Recipient Name],

I am writing to provide proof of my Tdap (Tetanus, Diphtheria, and Pertussis) vaccination, as requested.

Patient Name: [Your Full Name]

Date of Birth: [Your Date of Birth]

Vaccine Administered: Tdap

Date of Vaccination: [Date of Vaccination]

Administering Healthcare Provider: [Provider Name]

Provider Contact Information: [Provider Phone Number/Address]

Attached is a copy of my vaccination record for your review. Please let me know if you need any further information.

Thank you for your attention to this matter.

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]