

**COVID-19 Vaccine Attestation Form**

**This form is provided so that employees can attest to having received the COVID-19 Vaccine. Sharing this information is voluntary.**

By signing my name below, I certify the responses provided.

For purposes of this inquiry, an individual is considered “fully vaccinated” when it has been at least two weeks since receiving the final dose, as recommended by the manufacturer, of a vaccine that has been authorized by the FDA for use in the United States, including vaccinations that have been approved pursuant to an Emergency Use Authorization.

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position and Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaccine Status: (check one)

* Fully Vaccinated
* Partially Vaccinated
* Not Yet Vaccinated, but COVID-19 Appointment is Scheduled

**Optional information:**

Date(s) of COVID-19 Vaccination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COVID-19 Vaccine Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I understand I am required to provide accurate information in response to the questions above and that failure to do so may result in disciplinary action, up to and including termination. By signing above, I certify that I have accurately and truthfully answered the questions above. COVID-19 Vaccine information is maintained in the Environmental, Health and Safety Department and will not be part of an employee’s personnel file in HR.*