I, (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ attest that I am (check one box indicating current status)  fully vaccinated  partially vaccinated against COVID-19 and that I am unable to provide documentation as proof of my current vaccination status.

I understand the current definition of “fully vaccinated” to mean, two weeks (14 calendar days) have passed since receiving an FDA approved one-dose vaccine (Johnson & Johnson) or a second dose of an FDA approved mRNA vaccine (Moderna or Pfizer-BioNTech), and “partially vaccinated” means a second dose must still be obtained and/or 14 days have not passed since my final dose of a primary vaccine.

Please indicate the type (brand) of vaccination(s) received:

Johnson & Johnson

Moderna

Pfizer-BioNTech

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of vaccine administration. Please provide your best recollection of the dates if you are not certain:

First dose: \_\_\_/ \_\_\_/ \_\_\_\_ Second dose: \_\_\_/ \_\_\_/ \_\_\_\_ Booster: \_\_\_/ \_\_\_/ \_\_\_\_

Name of health care professional, clinic or other approved entity administering the vaccine (list all if more than one location provided the doses):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I declare [or certify, verify, or state] that this statement about my vaccination status is true and accurate. I understand that knowingly providing false information regarding my vaccination status on this form may subject me to legal or criminal penalties, or termination of employment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (signature) Date

**Please submit completed form to an HR representative upon completion.**