**COVID-19 Vaccination Attestation Form**

This form is a record which will be maintained in a confidential and secure location as the information on this form will be considered personal health information in accordance with the ADA.

Vaccination status will be determined by the proof provided by each employee. If an employee has been unable to obtain proof of their status (e.g. such records were lost or stolen), and if they have done their best to reach their vaccination provider to obtain a new copy or utilize their state department’s immunization information system to locate such confirmation, without success, the employee may attest to their vaccination status using this form.

**Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I assert that:**

1. **I am unable to locate any of the following documents due to their being lost or stolen:**

* The record of immunization from a health care provider or pharmacy;
* A copy of the COVID-19 Vaccination Record Card;
* A copy of medical records documenting the vaccination;
* A copy of immunization records from a public health, state, or tribal immunization information system;
* A copy of any other official documentation that contains the type of vaccine administered, date(s) of administration, and the name of the health care professional(s) or clinic site(s) administering the vaccine(s)

1. **I have made attempts to contact my vaccination provider or the state health department’s immunization information system and still have had no success in getting proof of my status.**
2. **I attest that I have been □ partially or □ fully vaccinated on the approximate dates below:**

Type of Vaccine Administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(s) of health care professionals or clinic site where administered:

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

Date of Dose 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Dose 2 (if 2-dose vaccine): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 criminal penalties.**

**Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**