

## Certification of Vaccination

**Please check the box below that coincides with your vaccination status and return this attestation form to your branch ED/administrator**

- ☐ I am fully vaccinated. Employees are considered “fully vaccinated” two weeks after completing the second dose of a two-dose COVID-19 vaccine (e.g., Pfizer or Moderna) or two weeks after receiving a single dose of a one-dose vaccine (e.g., Johnson & Johnson/Janssen).
- ☐ I am not yet fully vaccinated—I received my first dose of Moderna or Pfizer, and my second appointment is scheduled, or I received my final dose less than two weeks ago.
- ☐ I have not been vaccinated.
- ☐ Do you anticipate becoming fully vaccinated within the next 30 Days? Answer Y or N
- ☐ I decline to respond.

Employees who choose not to complete the form will be assumed to not be fully vaccinated for purposes of application of the safety protocols. If you are not vaccinated due to medical or religious reasons, please check either “I have not been vaccinated” or “I decline to respond.” Note that if you have already received one dose of a vaccine, but are not yet fully vaccinated, or if you received your final dose less than two weeks ago, then you will be treated as not fully vaccinated until you are at least two weeks past your final dose and resubmit your vaccination information.

If you choose to not be vaccinated due to medical or religious reasons, please state the specific reasons below:

- ☐ I attest that the information provided in this form is accurate and true to the best of my knowledge. I understand that a knowing and willful false statement on this form is considered falsification of Company records, a violation of Company policy, and will be subject to discipline up to and including termination of employment.

☐ Checking "I decline to respond" does not constitute a false statement. However, I do understand that should the interim final rule for vaccine requirements become law, and I am mandated to become fully vaccinated, the Company's knowledge of my vaccine status will become a condition of employment.

We are authorized to collect the information requested on this form pursuant to

**Purpose:** This information is being collected and maintained to promote the health and safety of Company patients, their family members, and employees consistent with guidelines established by the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA).

**Routine Uses:** While the information requested on this form is intended to be used primarily for internal purposes, in certain circumstances it may be necessary to disclose this information externally to a Federal, State, or local agency to the extent necessary to comply with laws governing reporting of communicable disease or other laws concerning health and safety in the work environment.

**Consequence of Failure to Provide Information:** Providing this information is voluntary. However, if you fail to provide this information, you will be treated as not fully vaccinated for purposes of implementing any future vaccination requirements mandated by Federal, State, or local agencies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Full Name (printed)

\_\_\_\_\_  
Branch/office

\_\_\_\_\_  
Job Title