**Employee COVID-19 Vaccination Status Form**

**PLEASE COMPLETE THE FORM TO DISCLOSE YOUR CURRENT VACCINATION STATUS.**

All [COMPANY NAME] employees are required to be fully vaccinated against COVID-19. Employees may request an exception on the basis of a medical condition or sincerely-held religious belief.

For purposes of this form, you 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).

Acceptable proof of vaccination includes documentation provided by a tribal, federal, state or local government, or a health care provider, that includes an individual’s name, date of birth, type of COVID-19 vaccination given, date or dates given, and the name and location of the health care provider or site where the vaccine was administered. Documentation may include but is not limited to a COVID-19 vaccination record card, a copy or digital picture of the vaccination record card, or a print-out from your state’s immunization registry.

| **Please select your vaccination status:** * I am fully vaccinated.
* I have received my first dose of Pfizer or Moderna, and have my second dose scheduled.
* I have received a single dose of the Johnson & Johnson/Janssen vaccine.
* I am not vaccinated, but plan to do so.
* I would like to request a medical exemption.
* I would like to request a religious exemption.
* I am not vaccinated, and I’m not planning to get vaccinated.
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**Employee Attestation:** I understand that I am required to provide the company with accurate information about my vaccination status and that failure to be truthful can subject me to discipline, up to and including termination of employment. I hereby certify that I have provided accurate and truthful information about my vaccination status in my answer to the questions above.

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

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

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_