Department of Veterans Affairs

COVID-19 VACCINATION

DATE *(MM/DD/YYYY)*: _____

I am a VHA: ☐ Employee ☐ Volunteer ☐ Other (ex: Trainee, Resident, Intern, Fee Basis, or Researcher)

If other, please indicate: Volunteer

CHECK ONE STATEMENT BELOW AND COMPLETE AND SIGN THE LAST SECTION OF THIS FORM PRIOR TO SUBMISSION TO EMPLOYEE OCCUPATIONAL HEALTH:

☐ I received the full COVID-19 vaccine series (any required documentation is attached).

☐ I have been granted a medical exemption from receiving the COVID-19 vaccine.

I have a contraindication for the COVID-19 vaccine as defined by Centers for Disease Control and Prevention (CDC). The reasons for contraindication must be recognized contraindications and precautions by the CDC, found here: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html, located under Interim Clinical Considerations for Use or Vaccine Indications. This has been discussed and acknowledged by my personal physician. I understand that by declining to receive the vaccine within eight weeks of publication of this directive, or within eight weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1193, COVID-19 Vaccination Program for VHA Health Care Personnel.

_____
Printed Physician Name and Address

_____ _____ _____
Physician Signature | Date *(MM/DD/YYYY)* | National Provider Identification Number

_____ _____ _____
Supervisor Signature | Date *(MM/DD/YYYY)* | Supervisor Email

☐ I notified my immediate supervisor in writing that I have a deeply held religious belief that prevents me from receiving the COVID-19 vaccine.

I understand that by declining to receive the vaccine within eight weeks of publication of this directive, or within eight weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1193, COVID-19 Vaccination Program for VHA Health Care Personnel.

_____ _____ _____
Supervisor Signature | Date *(MM/DD/YYYY)* | Supervisor Email

I have read and fully understand the information on this form and have been given the opportunity to have my questions answered. I understand that violation of the directive may result in disciplinary action up to and including removal from Federal service.

Name (print): _____ Last 4 SS#: _____

Dept./Serv: _____ Date *(MM/DD/YYYY)*: _____

Employee Signature: _____

Employees and volunteers provide this form to the VHA facility Employee Occupational Health Office. Secure electronic submission is permissible.

Health Professions Trainees requesting medical or religious exemptions provide this form to the Designated Education Officer (DEO); and proof of vaccination is provided to the DEO via the Trainee Qualifications and Credentials Verification Letter (TQCVL).