Department of Veterans Affairs

COVID-19 VACCINATION

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

I am a VHA: ☐ Employee ☐ Other - please indicate: _____

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 Employees and 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 Employees and 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: _____

VHA Title 38HCP are to provide this form to the VHA facility Employee Occupational Health Office. Secure electronic submission is permissible.