Department of Veteran	S Affairs COVID-19 VACCINATION
DATE (MM/DD/YYYY):	
I am a VHA: Employee	Other - please indicate: VOLUNTEER
CHECK ONE STATEMENT BELO SUBMISSION TO EMPLOYEE OO	W AND COMPLETE AND SIGN THE LAST SECTION OF THIS FORM PRIOR TO CUPATIONAL HEALTH:
I received the full COVID-19 v	accine series (any required documentation is attached).
I have a contraindication for the reasons for contraindication in https://www.cdc.gov/vaccines/2Fwww.cdc.gov%2Fvaccines/Considerations for Use or Vacunderstand that by declining the beginning employment, I must	exemption from receiving the COVID-19 vaccine.  e COVID-19 vaccine as defined by Centers for Disease Control and Prevention (CDC). The ust be recognized contraindications and precautions by the CDC, found here:  covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%  62Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html, located under Interim Clinical cine Indications. This has been discussed and acknowledged by my personal physician. I be receive the vaccine within eight weeks of publication of this directive, or within eight weeks of wear a face mask according to requirements and guidelines within VHA Directive 1193, m for VHA Employees and Health Care Personnel.
Printed Physician Name and A	ddress
Physician Signature	Date (MM/DD/YYYY) National Provider Identification Number
Supervisor Signature	Date (MM/DD/YYYY) Supervisor Email
COVID-19 vaccine.  I understand that by declining of beginning employment, I m	to receive the vaccine within eight weeks of publication of this directive, or within eight weeks ust wear a face mask according to requirements and guidelines within VHA Directive 1193, m for VHA Employees and Health Care Personnel.
Supervisor Signature	Date (MM/DD/YYYY) Supervisor Email
	e information on this form and have been given the opportunity to have my questions on of the directive may result in disciplinary action up to and including removal from Federal
Name (print):	Last 4 SS#:
Dept./Serv:	Date (MM/DD/YYYY):
Employee Signature:	
VHA Title 38HCP are to provide submission is permissible.	his form to the VHA facility Employee Occupational Health Office. Secure electronic
	Date of Birth:Home Address:
VA FORM JUL 2021 <b>10-263</b>	Phone Number:
	E-mail:

JUL 2021