**COVID-19 HCW/Essential Worker VACCINATION DECLINATION/VERIFICATION**

2021

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

I understand that due to the pandemic, combined with any additional personal risk factors *(work exposure, comorbidities, congregate or group living status, etc.)* I may be at increased risk of acquiring COVID-19 with the potential for severe and fatal consequences. I understand that if I acquire COVID-19 I will place my colleagues, family, and clients at increased risk for COVID-19 including the potential for severe and fatal consequences. I’ve received the COVID Vaccine

**INSTRUCTIONS**: complete Option 1 OR Option 2 citing reason.

**Option 1-**

* Proof of Vaccination:

□ I have received the COVID-19 vaccine.

Please indicate where and *provide proof of vaccination* with this form:

□ Primary Physician   
□ Hospital  
□ Pharmacy   
□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Option 2-**

I have received vaccine education materials and I have been provided the options to be vaccinated against COVID-19 at no charge to me. However, I decline the vaccination at this time. I understand that by declining this vaccine I continue to be at increased risk of acquiring COVID-19.

* Reason(s) for declination:

□ I was diagnosed with COVID and believe that I am immune.  
□ Other: Please specify:   
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**I acknowledge and confirm that the above information is correct.**

Signature: Date:

Please send signed form to: <insert email address>