COVID-19 Vaccine Attestation

This form is provided so that employees can attest to having received the COVID-19 Vaccine. Sharing this information is voluntary.

Today's Date: _____

Vaccine Certification:

By signing my name below, I certify that I have been fully vaccinated against COVID-19. “Fully vaccinated” means it has been two weeks since receiving either 1) both doses of either the Pfizer or Moderna vaccine, or 2) the single dose of the Johnson & Johnson vaccine.

Print Name _____

Position and Department _____

Signature _____

Optional information:

Date(s) of COVID-19 Vaccination**: _____**

COVID-19 Vaccine Brand: **_____**

Note: Employee medical records are maintained confidentially by Human Resources, separate from an employee's general personnel file. Information will only be shared with those who have a need to know for the purpose of performing their job in relation to health and safety of the campus.