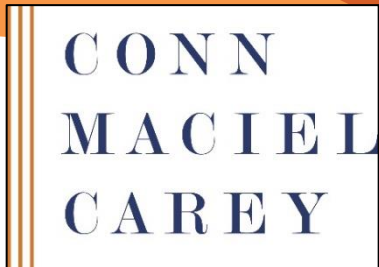


Self-Attestation of Vaccination Status



Employer/Business/Entity Name: _____

Employee First Name: _____

Employee Last Name: _____

Date of Birth: _____

I attest to the following:

I have lost and am otherwise unable to produce proof of vaccination status by any of the following:

- The record of immunization from a health care provider or pharmacy;
- A copy of the COVID-19 Vaccination Record Card;
- A copy of medical records documenting the vaccination;
- A copy of immunization records from a public health, state, or tribal immunization information system; or
- A copy of any other official documentation that contains the type of vaccine administered, date(s) of administration, and the name of the health care professional(s) or clinic site(s) administering the vaccine(s).

For purposes of this attestation, I understand that "fully vaccinated" means:

- (i) A person's status 2 weeks after completing primary vaccination with a COVID-19 vaccine with, if applicable, at least the minimum recommended interval between doses in accordance with the approval, authorization, or listing that is:
 - (A) Approved or authorized for emergency use by the FDA;
 - (B) Listed for emergency use by the World Health Organization (WHO); or
 - (C) Administered as part of a clinical trial at a U.S. site, if the recipient is documented to have primary vaccination with the active (not placebo) COVID-19 vaccine candidate, for which vaccine efficacy has been independently confirmed (e.g., by a data and safety monitoring board) or if the clinical trial participant at U.S. sites had received a COVID-19 vaccine that is neither approved nor authorized for use by FDA but is listed for emergency use by WHO; or
- (ii) A person's status 2 weeks after receiving the second dose of any combination of two doses of a COVID-19 vaccine that is approved or authorized by the FDA, or listed as a two-dose series by the WHO (i.e., a heterologous primary series of such vaccines, receiving doses of different COVID-19 vaccines as part of one primary series). The second dose of the series must not be received earlier than 17 days (21 days with a 4-day grace period) after the first dose.

Vaccination Status <i>(check one)</i>	<input type="checkbox"/> I am fully vaccinated <input type="checkbox"/> I am partially vaccinated
Type of Vaccine Administered <i>(fill in the type of vaccine; e.g., Pfizer, Moderna, Johnson & Johnson, etc.)</i>	
Date(s) of Administration <i>(fill in the appropriate blanks)</i>	1. I received a two-dose vaccine. My first dose was administered on _____[date], and my second dose was (or will be) administered on _____[date]; OR 2. I received a one-dose vaccine, which was administered on _____[date].
Name of the Health Care Professional(s) or Clinic Site(s) Administering the Vaccine(s) <i>(fill in the name of the health care professional(s) or clinic site(s) administering the vaccine(s); e.g., Dr. Smith, State Convention Center, XYZ Pharmacy)</i>	

I declare (or certify, verify, or state) that this statement about my vaccination status is true and accurate. I understand that knowingly providing false information regarding my vaccination status on this form may subject me to criminal penalties.

Signature: _____

Date: _____