Intermountain COVID-19 Vaccination Disclosure Form

Worker Name:

Agency Name:

COVID-19 Vaccination Status:

The following information is voluntary. If you choose not to disclose, please indicate below.

The Centers for Disease Control and Prevention (CDC) require hospitals to continue reporting COVID-19 vaccination status of all healthcare personnel. Your responses are voluntary but help Intermountain fulfill the CDC's requirement in reporting this information.

[ ] **I have received the COVID-19 vaccine.**

- **Vaccine Name:** [Enter Vaccine Name, e.g., Pfizer, Moderna, Novavax, Johnson & Johnson (no longer available)]
- **Date of First Dose:** [MM/DD/YYYY]
- **Date of Second Dose (if applicable):** [MM/DD/YYYY]
- **OR Date of Single-Dose Vaccine:** [MM/DD/YYYY]

[ ] **I have received a the COVID-19 Booster vaccine. (List most recently received booster)**

- **Vaccine Name:** [Enter Vaccine Name, e.g., Pfizer, Moderna]
- **Date of Dose:** [MM/DD/YYYY]
- **Vaccine Name:** [Enter Vaccine Name, e.g., Pfizer, Moderna]
- **Date of Dose:** [MM/DD/YYYY]

[ ] **I choose not to disclose if I have had a COVID-19 Vaccine or booster**

Worker Signature: _____

Date: [MM/DD/YYYY]