I, _____ attest that I am □ fully vaccinated / □ partially vaccinated against COVID-19 and am unable to produce proof of vaccination.

I understand fully vaccinated to mean two weeks (14 days) have passed since receiving either a one-dose vaccine or a second dose of a two-dose vaccine; and partially vaccinated means a second dose must still be obtained and/or two weeks have not passed since my final dose.

Type of vaccination received:

- Johnson & Johnson
- Moderna
- Pfizer-BioNTech
- Other: _____

Dates of vaccine administration: First dose: ___/___/___ Second dose: ___/__/____

I do not know the dates of my vaccine administration(s).

Name of health care professional or clinic administering the vaccine:

_____

Additional comments:

_____

_____

_____

I declare 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.

Signed: _____ Date: _____

Printed Name: _____