COVID-19 VACCINATION VA FORM 10-263

I am a VHA: ___ Employee ___ Volunteer ___ Other (ex: Trainee, Resident, Intern, Fee Basis, or Researcher) Please indicate: _____

CHECK ONE STATEMENT BELOW AND COMPLETE AND SIGN THE LAST SECTION OF THIS FORM PRIOR TO SUBMISSION TO EMPLOYEE OCCUPATIONAL HEALTH:

☐ I have received a complete COVID-19 vaccine series (any required documentation is attached).

☐ I have been granted a medical exemption from receiving the COVID-19 vaccine. I have a contraindication for the COVID-19 vaccine as defined by Centers for Disease Control and Prevention (CDC). The reasons for contraindication must be recognized contraindications and precautions by the CDC, found here: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html, located under Interim Clinical Considerations for Use or Vaccine Indications). This has been discussed and acknowledged by my personal physician. I understand that by declining to receive the vaccine within eight weeks of publication of this directive, or within eight weeks of beginning employment, I must wear a face mask according to requirements and guidelines within VHA Directive 1193, Coronavirus Disease 2019 Vaccination Program for VHA Health Care Personnel.

_____
Printed Physician Name and Address

_____ _____ _____
Physician Signature Date National Provider Identification Number

_____ _____ _____
Supervisor Signature Date Supervisor Email