Department of Veterans Affairs	COVI	D-19 VACCINATION
DATE (MM/DD/YYYY):		
I am a VHA: X Employee Other - please indic	cate:	
CHECK ONE STATEMENT BELOW AND COMPLETE AND SIGN THE LAST SECTION OF THIS FORM PRIOR TO SUBMISSION TO EMPLOYEE OCCUPATIONAL HEALTH:		
I received the full 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:		