# COVID-19 VACCINATION VERIFICATION OR REQUIRED TESTING FORM

**Employee Name:**_____

**Employee ID Number:**_____

**Vaccine Received (please select one):**

☐ Johnson & Johnson ☐ Moderna ☐ Pfizer

**Please list the date of vaccine administration for first dose and, if applicable, second dose.**

**Date of Dose 1:**_____ **Date of Dose 2 (if applicable):**_____

**Please select one of the following modes of proof of vaccination:**

☐ 1) COVID-19 Vaccination Record Card (issued by the Department of Health and Human Services Centers for Disease Control & Prevention or WHO Yellow Card) which includes name of person vaccinated, type of vaccine provided and date last dose administered);

☐ 2) A copy or photo of a Vaccination Record Card or an electronic vaccination record;

☐ 3) Documentation of COVID-19 vaccination from a health care provider;

☐ 4) Digital record that includes a QR code, name, date of birth, vaccine dates and vaccine type, and which confirms the vaccine record as an official record of the state of California;

☐ 5) I participated in a county clinic and I received my vaccination series at one of the following sites please check one, and consent to the County accessing my vaccination records from the below checked database:

☐ Administration Drive or La Plaza County Clinics between the dates of 1/12/2021 and 3/3/2021

☐ Crisis Stabilization Unit Clinics

## Employee Authorization to Use and Disclose Medical Information

I authorize the County of Sonoma pursuant to the California Confidentiality of Medical Information Act to use and disclose information regarding my COVID-19 vaccination status or COVID testing results to HR and my Department's HR, management and/or supervisors for five years from the date of execution of this Authorization, for only legitimate, non-discriminatory business purposes where my vaccination status is necessary for the County to make work-related decisions authorized by or in order to comply with federal, state, or local laws or

regulations that takes an employee's vaccination status or test results into account. I understand that I have the right to receive a copy of this authorization upon request. I hereby attest that I am signing this authorization voluntarily**.**

Check one of the following:

☐ By checking this box and by signing below, I acknowledge, understand, authorize, and agree with the statements above, and hereby attest that I am fully vaccinated against COVID-19, I have provided proof, and I authorize the County to use and only disclose my COVID-19 vaccination status as outlined above.

☐ I have not provided proof and as a result, I understand I am *required and consent* to participate in regular testing, as outlined by the Public Health Order(s) or as required by my employer. I must also observe all other infection control requirements, including masking. I understand that I may undergo testing on my own and provide the results to the County, or I will participate in the County sponsored testing. As part of the testing requirements, I will also complete the COVID-19 Testing Consent Authorization and Release form. *By signing below, I acknowledge, understand, authorize, and agree with the above statements.*

**Employee Signature:**_____ **Date:**_____

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**Department Verification:**

☐ *By checking this box and by signing below, I acknowledge that I have visually verified the mode of proof provided by the employee.*

☐ *Proof was not provided, I have collected the Testing Consent, Auth & Release form.*

Validated by:_____

Signature:_____ Date:_____

☐ *Entered into eP IHHR_MONITOR screen by:*_____

**This form is to be kept in the confidential medical file.**