# CLINICAL EDUCATION VACCINATION STATUS FORM

## Student or Faculty Information

Full Name: _____ Date: _____
*Last* *First* *M.I.*

Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Phone: _____ Email _____

Student or Faculty?: _____ College LOLA No.: _____ Program: _____

Clinical Education Site: _____

Have you received a COVID-19 vaccine? *(Attach copy of record)* YES ☐ NO ☐ If yes, when? _____

Have you received a COVID-19 booster? *(Attach copy of record)* YES ☐ NO ☐ If yes, when? _____

Are you requesting an exemption from the CMS vaccine mandate? YES ☐ NO ☐

If yes, please identify the basis of your request:

☐ Medically Contraindicated ☐ Written Dissent / Other (Additional info *may* be provided below)

_____

## *OFFICIAL USE ONLY BELOW THIS LINE*

Exemption Request Granted: _____
(Signature)

_____
(Printed Name and Title)

_____
Date