COVID-19 Vaccination Status Form

Privacy Act Statement

Overview:

We value the trust and confidence that you place in the NIH Occupational Medical Service (OMS), and we are committed to protecting your privacy. The Personally Identifiable Information (PII) about you collected in this form will be stored in your OMS Electronic Health Record (EHR). The OMS EHR is a government application. The OMS EHR application is hosted on internal servers operated by the Office of Research Services (ORS), Office of Innovation and Information Technology (OIIT) and by the National Institutes of Health Clinical Center's (NIH/CC) Department of Clinical Research Informatics (DCRI). The Federal Government has implemented a COVID-19 vaccination requirement for all federal employees and contractors. This is a result of two Executive Orders, in combination with implementation guidelines issued by the Safer Federal Workforce Task Force in President Biden's Executive Order 13991. The information collected in this notice will be used to ensure compliance with these requirements.

Authority:

Pursuant to the Executive Order on Requiring Coronavirus Disease 2019 Vaccination for Federal Employees, the Executive Order on Ensuring Adequate COVID Safety Protocols for Federal Contractors requires all persons to receive the COVID-19 vaccination, and 5 C.F.R. § 339.205 under which OPM authorizes agencies to establish immunization programs for employees who are exposed to significant health or safety risks by nature of their work. The legal authority to operate and maintain this Privacy Act System of Records is 42 U.S.C. 241 and 5 U.S.C. 7902.

Purpose:

This information is being collected and maintained to promote the safety of the Federal workplace consistent with the above-referenced authorities, the COVID-19 Workplace Safety: Agency Model Safety Principles established by the Safer Federal Workforce Task Force, and guidance from the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA).

Routine Uses:

While the information requested on this form is intended to be used primarily for internal purposes, in certain circumstances it may be necessary to disclose this information externally, for example to disclose information to: a Federal, State, or local agency to the extent necessary to comply with laws governing reporting of immunizations or safety in the work environment; to contractors or volunteers as necessary to perform their duties for the Federal Government; to other agencies, courts, and persons as necessary and relevant in the course of litigation, and as necessary and in accordance with requirements for law enforcement; or to a person authorized to act on your behalf. A complete list of the routine uses can be found in the system of records notice associated with this collection of information [09-25-0166, Radiation and Occupational Safety and Health Management Information Systems, HHS/NIH/ORS](#), [09-40-0002, Public Health Service (PHS) Commissioned Corps Commissioned Corps Medical Records, HHS/PSC/HRS](#), and [OPM/GOVT-10, Employee Medical File System Records](#).

Consequences for Not Providing Information:

Providing this information is required as outlined in the Executive Orders and the information provided by the Safer Federal Workforce Taskforce. If you fail to provide this information, you will be treated as not fully vaccinated. Additionally, failure to complete this form, or provide vaccination information, may result in disciplinary action.

Point of Contact Information:

If you have any questions or concerns, please contact the OMS Covid-19 Vaccination Program at OMSCovidVaccineProgram@mail.nih.gov, or the Medical Director, NIH Occupational Medical Service, at 301-496-4411 or mail to: NIH Occupational Medical Service, Bldg 10, Rm 6C 310; 10 Center Drive, MSC 1584; Bethesda, MD 20892; attn: Medical Director.

Please click the box below to acknowledge the Privacy Act Notice and then click "Next Page" to continue.

* must provide value

✅ **By checking this box, I hereby accept the Privacy Act Notice.**

COVID-19 Vaccination Status Form

Employee Information

Introduction

The Office of Research Services, Division of Occupational Health and Safety, Occupational Medical Service already has the information for those vaccinated within the NIH COVID-19 Vaccine Program. Those vaccinated within the NIH vaccination program are not being asked to complete this form at this time.

This form is for those who have declined to be vaccinated or who are fully or partially vaccinated through publicly available means (e.g., in the community at mass vaccination sites, pharmacies, healthcare facilities).

Providing a knowing and willful false statement on this form may be punishable by fine and/or imprisonment (18 U.S.C. 1001) and could result in additional administrative action, including an adverse personnel action, up to and including removal from your position.

Were you vaccinated <u>only at NIH</u>?   (i.e., you received BOTH doses of Moderna or Pfizer, or received Janssen (Johnson & Johnson) at NIH)

If you select YES and received your full series of vaccinations at NIH, then you DO NOT NEED TO SUBMIT THIS FORM.

* must provide value

Yes

No

reset

First Name

* must provide value

Test

Middle Name

Middle Name

Last Name

* must provide value

Test

NIH ID Number (no dashes)

* must provide value

0000000000

0 characters remaining

Enter your NIH ID Number, including any zeros, and without any dashes (e.g., 0012345678).

Need help finding your NED ID Number?

✓ Show Help

Your NIH ID Number is the 10-digit Personal Identifier on the back of your PIV card. You can also look it up by searching your name in the NIH Enterprise Directory at https://ned.nih.gov (must be connected to the NIH Network or VPN).

Email Address

* must provide value

test@test.com

Please enter your email address so that you may be contacted if there are questions on your submission.

Please note that at the bottom of any page in this form, you can click "Save & Return Later" to get a personalized survey link and a Return Code.
***Important*: To use this option, you will need both the survey link and your return code. Be sure to copy down your Return Code from the Save & Return page -- it will NOT be emailed to you with the link.**

COVID-19 Vaccination Status Form

Vaccination Information

Persons are considered "fully vaccinated" two weeks after completing the full series of a COVID-19 vaccine approved or authorized for emergency use by the U.S. Food and Drug Administration or that has been listed for emergency use by the World Health Organization (e.g., Pfizer, Moderna, Janssen, AstraZeneca/Oxford, etc.), or a full vaccine series (not a placebo) in a clinical trial (e.g., Novavax).

If you have received all the required doses but it has been less than two weeks since your last dose, select the "I am fully vaccinated" option to complete this form. *However, you are still subject to the safety requirements of a person not fully vaccinated until the two weeks have passed.*

If you have received one dose of a two-dose vaccine, even if you are scheduled for your second dose, select "I am not fully vaccinated."

If you are not vaccinated due to medical or religious reasons, select "I am not fully vaccinated."

For persons who choose not to complete the form, it will be assumed that they are not fully vaccinated for the purposes of applicable safety measures and/or compliance with vaccination policy requirements.

Please click the box that describes your current COVID-19 vaccination status

* must provide value

| I am fully vaccinated. |
| I am not fully vaccinated. |

reset

<< Previous Page

Next Page >>

Save & Return Later

COVID-19 Vaccination Status Form

Additional Information

Vaccine Manufacturer
* must provide value

| Moderna |
| Pfizer-BioNTech |
| Janssen (Johnson & Johnson) |
| Other |

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Dose 1 Information

First Dose Date
* must provide value

09-01-2021 📅 M-D-Y

Please enter the date that you received your first dose.

Health care professional or clinic site who administered your Dose 1
* must provide value

CVS

e.g., CVS, Six Flags

Select the state where you received your Dose 1
* must provide value

Maryland (MD)

Vaccine Lot Number (if known)

ABCD123

Dose 2 Information

Second Dose Date
* must provide value

09-22-2021 📅 M-D-Y

Please enter the date that you received your second dose.

Health care professional or clinic site who administered your Dose 2
* must provide value

CVS

e.g., CVS, Six Flags

Select the state where you received your Dose 2
* must provide value

Maryland (MD)

Vaccine Lot Number (if known)

ABCD123

Upload Proof of Vaccination

Acceptable forms of documentation include a copy of:

- The record of immunization from a health care provider or pharmacy
- The COVID-19 Vaccination Record Card (CDC Form MLS-319813_r, published on September 3, 2020)
- Medical records documenting the vaccination
- Immunization records from a public health or state immunization information system

Test_UploadFile.xlsx (0.01 MB)

⬆ Upload new version   or   🗑 Remove file

(required)

⊕ **I need to upload a second file (optional)**

If you are finished and ready to submit your information, click Submit.

Notice: By clicking Submit, I understand that a knowing and willful false statement on this form may be punishable by fine and/or imprisonment (18 U.S.C. 1001) and could result in additional administrative action, including an adverse personnel action, up to and including removal from my position.

If you are not ready to submit your form, you can click "Save & Return Later" to send a unique return link to your email. **Important: To use this option, you must copy down your Return Code from the Save & Return page since it will NOT be emailed to you with the link.**

[<< Previous Page]

[Submit]

[Save & Return Later]