COVID-19 Vaccination Status Form

Privacy Act Statement

This statement is provided pursuant to the Privacy Act of 1974 (5 U.S.C. § 552a): The information requested in the COVID-19 Case Management System is authorized to be collected pursuant to NIH Policy Manual 0004 NIH COVID-19 Vaccination Policy for Healthcare Workforce, Department of Health and Human Services (HHS) memo (Aug. 6, 2021), Policy to Require COVID-19 Vaccinations for Certain HHS Employees and Other Staff, section 402 of the Public Health Service Act, the Office of Personnel Management (OPM) regulation 5 C.F.R. § 339.205, Executive Order 13991, Protecting the Federal Workforce and Requiring Mask-Wearing (Jan. 20, 2021), Executive Order 12196, Occupational Safety and Health Program for Federal Employees (Feb. 26, 1980), and 5 U.S.C. chapters 11 and 79.

The COVID-19 Case Management System collects records of vaccinations, testing and contact tracing. Providing the requested information is voluntary, however declining may result in being treated as not fully vaccinated for purposes of implementing safety measures, including with respect to mask wearing, physical distancing, testing, travel, and quarantine. This information is being collected and maintained to promote the safety of Federal buildings and the Federal workforce 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).

The information you provide will be included in a Privacy Act system of records and will be used and may be disclosed for the purposes and routine uses described and published in the following System of Records Notices (SORN): OPM/GOVT-10, Employee Medical File System of Records, 75 Fed. Reg. 35099 (June 21, 2010), amended 80 Fed. Reg. 74815 (Nov. 30, 2015); 09-25-0166 Radiation and Occupational Safety and Health Management Information Systems, HHS/NIH/ORS.

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.

OMB# _______ EXPIRATION DATE: __/__/____

Public reporting burden for this collection of information is estimated to average 5 minute per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA 0975-0771. Do not return the completed form to this address.

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

☐ By checking this box, I hereby acknowledge the Privacy Act Notice.

Employee Information

Were you vaccinated only at NIH? (i.e., you received all doses, including any boosters, at NIH) If you select YES and received all doses/boosters at NIH, then you DO NOT NEED TO SUBMIT THIS FORM.

◯ Yes ◯ No

First Name ______________________

Middle Name ______________________

Last Name ______________________

NIH ID Number (no dashes) ______________________
(Enter your NIH ID Number, including any zeros, and without any dashes (e.g., 0012345678).)

Please make sure your NIH ID Number has all 10 digits and DOES NOT contain dashes.

Need help finding your NED ID Number? ☐ Show Help

Ways to find your NIH ID Number:

The 10-digit Personal Identifier on the back of your PIV card (see image below). Look it up by searching your name in the NIH Enterprise Directory (NED) at https://ned.nih.gov (must be connected to the NIH Network or VPN). If you do not have access to the NIH Network, your Administrative Officer or Human Resources Specialist can look it up on your behalf.

Email Address
(either NIH or personal email) ______________________
(Enter your email so that you may be contacted if there are questions on your submission.)

Choose Your Form

Do you need to report your first dose(s)?

If you have previously completed this form to report your Primary Vaccination Series (Dose 1, Dose 2, etc.), then you do not need to complete this part again unless you were notified otherwise.

◯ YES - I need to report my initial vaccine dose(s) ◯ NO - I have already reported my initial vaccine dose(s)

Note: You will have an opportunity to submit any additional doses or boosters after you enter your initial dose information.

Please review your information. If you need to make changes, click the Previous Page button at the bottom of the screen.

First Name: [first_name]
Middle Name: [middle_name]
Last Name: [last_name]
NED ID: [hhs_id]
Email Address: [email_address]

If this information is correct, click Next Page to continue to the next section.

Vaccination Information

Were you vaccinated only at NIH? (i.e., you received BOTH of your first doses of Moderna or Pfizer, or received Janssen (Johnson & Johnson) at NIH) If you select YES and received your initial vaccinations at NIH, then you DO NOT NEED TO SUBMIT THIS FORM.

◯ Yes ◯ No

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	◯ I am fully vaccinated. ◯ I am not fully vaccinated.
Have you received Dose 1 and are scheduled to receive your Dose 2 at a later date?	◯ Yes ◯ No

Additional Information

Are you partially vaccinated for COVID-19?	◯ NO - I have not received any doses. ◯ YES - I have received ONE DOSE of a two-dose vaccine.
Vaccine Manufacturer	◯ Moderna ◯ Pfizer-BioNTech ◯ Janssen (Johnson & Johnson) ◯ Other
Vaccine Manufacturer	◯ Moderna ◯ Pfizer-BioNTech ◯ Other
Other Manufacturer:	____________________________ (Enter the vaccine manufacturer (e.g., AstraZeneca/Oxford, Novavax, etc.))
How many doses did you receive of this vaccine?	◯ One ◯ Two
Dose 1 Information	
First Dose Date (you have not received a second dose)	____________________________ (Please enter the date that you received your first dose.)
Vaccination dates must be on or before today's date.	
First Dose Date	____________________________ (Please enter the date that you received your first dose.)
Vaccination dates must be on or before today's date.	

Select the state where you received your Dose 1

◯ Alabama (AL)
◯ Alaska (AK)
◯ American Samoa (AS)
◯ Arizona (AZ)
◯ Arkansas (AR)
◯ California (CA)
◯ Colorado (CO)
◯ Connecticut (CT)
◯ Delaware (DE)
◯ District of Columbia (DC)
◯ Federated States of Micronesia (FM)
◯ Florida (FL)
◯ Georgia (GA)
◯ Guam (GU)
◯ Hawaii (HI)
◯ Idaho (ID)
◯ Illinois (IL)
◯ Indiana (IN)
◯ Iowa (IA)
◯ Kansas (KS)
◯ Kentucky (KY)
◯ Louisiana (LA)
◯ Maine (ME)
◯ Marshall Islands (MH)
◯ Maryland (MD)
◯ Massachusetts (MA)
◯ Michigan (MI)
◯ Minnesota (MN)
◯ Mississippi (MS)
◯ Missouri (MO)
◯ Montana (MT)
◯ Nebraska (NE)
◯ Nevada (NV)
◯ New Hampshire (NH)
◯ New Jersey (NJ)
◯ New Mexico (NM)
◯ New York (NY)
◯ North Carolina (NC)
◯ North Dakota (ND)
◯ Northern Mariana Islands (MP)
◯ Ohio (OH)
◯ Oklahoma (OK)
◯ Oregon (OR)
◯ Palau (PW)
◯ Pennsylvania (PA)
◯ Puerto Rico (PR)
◯ Rhode Island (RI)
◯ South Carolina (SC)
◯ South Dakota (SD)
◯ Tennessee (TN)
◯ Texas (TX)
◯ Utah (UT)
◯ Vermont (VT)
◯ Virgin Islands (VI)
◯ Virginia (VA)
◯ Washington (WA)
◯ West Virginia (WV)
◯ Wisconsin (WI)
◯ Wyoming (WY)
◯ Other - International

Administration Site (select one)

◯ Mass Vaccination Site
◯ Pharmacy
◯ Primary Care Physician
◯ Other

Vaccine Lot Number (if known)

____

Dose 2 Information

Second Dose Date

____
(Please enter the date that you received your second dose.)

Dose 2 date must be after Dose 1 date.

Dose 1 and 2 dates must be on or before today's date.

If you have not received Dose 2, please select the "I am not fully vaccinated" option on the previous page.

Select the state where you received your Dose 2

◯ Alabama (AL)
◯ Alaska (AK)
◯ American Samoa (AS)
◯ Arizona (AZ)
◯ Arkansas (AR)
◯ California (CA)
◯ Colorado (CO)
◯ Connecticut (CT)
◯ Delaware (DE)
◯ District of Columbia (DC)
◯ Federated States of Micronesia (FM)
◯ Florida (FL)
◯ Georgia (GA)
◯ Guam (GU)
◯ Hawaii (HI)
◯ Idaho (ID)
◯ Illinois (IL)
◯ Indiana (IN)
◯ Iowa (IA)
◯ Kansas (KS)
◯ Kentucky (KY)
◯ Louisiana (LA)
◯ Maine (ME)
◯ Marshall Islands (MH)
◯ Maryland (MD)
◯ Massachusetts (MA)
◯ Michigan (MI)
◯ Minnesota (MN)
◯ Mississippi (MS)
◯ Missouri (MO)
◯ Montana (MT)
◯ Nebraska (NE)
◯ Nevada (NV)
◯ New Hampshire (NH)
◯ New Jersey (NJ)
◯ New Mexico (NM)
◯ New York (NY)
◯ North Carolina (NC)
◯ North Dakota (ND)
◯ Northern Mariana Islands (MP)
◯ Ohio (OH)
◯ Oklahoma (OK)
◯ Oregon (OR)
◯ Palau (PW)
◯ Pennsylvania (PA)
◯ Puerto Rico (PR)
◯ Rhode Island (RI)
◯ South Carolina (SC)
◯ South Dakota (SD)
◯ Tennessee (TN)
◯ Texas (TX)
◯ Utah (UT)
◯ Vermont (VT)
◯ Virgin Islands (VI)
◯ Virginia (VA)
◯ Washington (WA)
◯ West Virginia (WV)
◯ Wisconsin (WI)
◯ Wyoming (WY)
◯ Other - International

Administration Site (select one)

◯ Mass Vaccination Site
◯ Pharmacy
◯ Primary Care Physician
◯ Other

Vaccine Lot Number (if known)

____

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 ______ (required)

☐ I need to upload a second file (optional)

Upload Proof of Vaccination (optional second file)

Select a reason for not receiving full vaccination (whether partially vaccinated or not)

◯ I request a medical exemption
◯ I request a religious exemption

Please note that you will be contacted with further information.

Verify Your Information

Please review your information and click Submit at the bottom of the page. If you need to make changes, click the Previous Page button.

Please review your information. If you need to make changes, click the Previous Page button two times to return to the entry form.

First Name: [first_name]
Middle Name: [middle_name]
Last Name: [last_name]
NED ID: [hhs_id]
Email Address: [email_address]

Click Submit to continue to the Booster and/or Dose 3 Form.

Verify Vaccination Information Vaccination Status: [vax_status]
Manufacturer: [vax_manufacturer]

Verify Vaccination Information Vaccination Status: [vax_status]
Manufacturer: [partial_vax_manufacturer]

Verify Vaccination Information Vaccination Status: [vax_status]
Manufacturer: [manufacturer_other]

Verify Dose 1 Information Date (mm-dd-yyyy): [date_first_dose]
State Administered: [state1]
Site Administered: [admin_site_primary1]
Lot Number: [lot_num1]

Verify Dose 1 Information Date (mm-dd-yyyy): [partial_date_first_dose]
State Administered: [state1]
Site Administered: [admin_site_primary1]
Lot Number: [lot_num1]

Verify Dose 2 Information Date (mm-dd-yyyy): [date_second_dose]
State Administered: [state2]
Site Administered: [admin_site_primary2]
Lot Number: [lot_num2]

Proof of Vaccination File: [vax_card1:label] [vax_card1:inline]

Second Proof of Vaccination File: [vax_card1:label] [vax_card2:inline]

Reason not fully vaccinated: [not_vax].

Do you need to report a Booster and/or extra dose due to a medical condition (Dose 3)?

◯ Yes ◯ No

If your information above is complete and accurate to the best of your knowledge, 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.

Booster and Dose 3 Form

COVID-19 Booster and Additional Dose Information

Did you receive your COVID-19 Booster Dose at NIH? If you select YES and received your booster at NIH, then you DO NOT NEED TO SUBMIT THIS FORM. The form will end and your response will not be saved.

◯ Yes ◯ No

Select the vaccination type you would like to report first. You may enter additional doses on the next page.	◯ Booster Dose ◯ Dose 3 (immunocompromised)
[vax_type_1] Information	
Manufacturer	◯ Moderna ◯ Pfizer-BioNTech ◯ Janssen (Johnson & Johnson) ◯ Other
Other Manufacturer:	____________________________ (Enter the vaccine manufacturer (e.g., AstraZeneca/Oxford, Novavax, etc.))
Lot Number (if known)	____________________________
Date of Vaccination	____________________________ (Please enter the date that you received your third dose.)

Vaccination date must be on or before today's date!

State where you received your vaccination

◯ Alabama (AL)
◯ Alaska (AK)
◯ American Samoa (AS)
◯ Arizona (AZ)
◯ Arkansas (AR)
◯ California (CA)
◯ Colorado (CO)
◯ Connecticut (CT)
◯ Delaware (DE)
◯ District of Columbia (DC)
◯ Federated States of Micronesia (FM)
◯ Florida (FL)
◯ Georgia (GA)
◯ Guam (GU)
◯ Hawaii (HI)
◯ Idaho (ID)
◯ Illinois (IL)
◯ Indiana (IN)
◯ Iowa (IA)
◯ Kansas (KS)
◯ Kentucky (KY)
◯ Louisiana (LA)
◯ Maine (ME)
◯ Marshall Islands (MH)
◯ Maryland (MD)
◯ Massachusetts (MA)
◯ Michigan (MI)
◯ Minnesota (MN)
◯ Mississippi (MS)
◯ Missouri (MO)
◯ Montana (MT)
◯ Nebraska (NE)
◯ Nevada (NV)
◯ New Hampshire (NH)
◯ New Jersey (NJ)
◯ New Mexico (NM)
◯ New York (NY)
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◯ Utah (UT)
◯ Vermont (VT)
◯ Virgin Islands (VI)
◯ Virginia (VA)
◯ Washington (WA)
◯ West Virginia (WV)
◯ Wisconsin (WI)
◯ Wyoming (WY)
◯ Other - International

Administration Site (select one)

◯ Mass Vaccination Site
◯ Pharmacy
◯ Primary Care Physician
◯ Other

Upload Proof of Vaccination ______ (required) Click Upload file above and choose a file format such as a PDF or an image format such as a JPEG, PNG, or TIFF file. Please note, HEIC file format is NOT accepted.

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

Would you like to enter another booster or additional dose?

◯ Yes, I need to add more
◯ No, I'm done

COVID-19 Booster and Additional Dose Information

Select the next vaccination type you would like to report. You may enter additional doses on the next page.	◯ Booster Dose ◯ Dose 3 (immunocompromised)
[vax_type_2] Information	
Manufacturer	◯ Moderna ◯ Pfizer-BioNTech ◯ Janssen (Johnson & Johnson) ◯ Other
Other Manufacturer:	______________________________ (Enter the vaccine manufacturer (e.g., AstraZeneca/Oxford, Novavax, etc.))
Lot Number (if known)	______________________________
Date of Vaccination	______________________________ (Please enter the date that you received your third dose.)
Vaccination date must be on or before today's date!	

State where you received your vaccination

◯ Alabama (AL)
◯ Alaska (AK)
◯ American Samoa (AS)
◯ Arizona (AZ)
◯ Arkansas (AR)
◯ California (CA)
◯ Colorado (CO)
◯ Connecticut (CT)
◯ Delaware (DE)
◯ District of Columbia (DC)
◯ Federated States of Micronesia (FM)
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◯ Guam (GU)
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◯ Idaho (ID)
◯ Illinois (IL)
◯ Indiana (IN)
◯ Iowa (IA)
◯ Kansas (KS)
◯ Kentucky (KY)
◯ Louisiana (LA)
◯ Maine (ME)
◯ Marshall Islands (MH)
◯ Maryland (MD)
◯ Massachusetts (MA)
◯ Michigan (MI)
◯ Minnesota (MN)
◯ Mississippi (MS)
◯ Missouri (MO)
◯ Montana (MT)
◯ Nebraska (NE)
◯ Nevada (NV)
◯ New Hampshire (NH)
◯ New Jersey (NJ)
◯ New Mexico (NM)
◯ New York (NY)
◯ North Carolina (NC)
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◯ South Carolina (SC)
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◯ Texas (TX)
◯ Utah (UT)
◯ Vermont (VT)
◯ Virgin Islands (VI)
◯ Virginia (VA)
◯ Washington (WA)
◯ West Virginia (WV)
◯ Wisconsin (WI)
◯ Wyoming (WY)
◯ Other - International

Administration Site (select one)	◯ Mass Vaccination Site ◯ Pharmacy ◯ Primary Care Physician ◯ Other
Use the file uploaded on the previous page?	◯ Use the file I already uploaded ◯ I need to upload a different file

Use this file: [vax_card_1:label]

[vax_card_1:inline]

Upload Proof of Vaccination ______ (required) Click Upload file above and choose a file format such as a PDF or an image format such as a JPEG, PNG, or TIFF file. Please note, HEIC file format is NOT accepted.

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

Would you like to enter another booster or additional dose?	◯ Yes, I need to add more ◯ No, I'm done

Verify Your information

Please review your information and click Submit at the bottom of the page. If you need to make changes, click the Previous Page button.

First Name: [first_name]
Middle Name: [middle_name]
Last Name: [last_name]
NED ID: [hhs_id]
Email Address: [email_address]

Verify [vax_type_1] Information Manufacturer: [manufacturer_1]
Other (if selected): [manufacturer_other_1]
Date (mm-dd-yyyy): [dose_date_1]
State Administered: [state_1]
Site Administered: [admin_site_1]
Lot Number: [lot_num_1]
Proof of Vaccination: [vax_card_1:inline]

Verify [vax_type_2] Information Manufacturer: [manufacturer_2]
Other (if selected): [manufacturer_other_2]
Date (mm-dd-yyyy): [dose_date_2]
State Administered: [state_2]
Site Administered: [admin_site_2]
Lot Number: [lot_num_2]
Proof of Vaccination: [vax_card_2:inline]

If your information above is complete and accurate to the best of your knowledge, 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.