NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

OMB Approved
OMB No. 0920-1317
Exp. Date 01/31/2024
www.cdc.gov/nhsn

*Facility ID:	Event #:
*Staff ID:	
*Name: First: Middle: Last:	
*Gender: F M Other	*Date of Birth: ___/___/____
*Ethnicity (specify): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to respond ☐ Unknown	*Race (specify): ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined to respond ☐ Unknown

Event Details
*Event Type: **COVID-19** *Date of Event: __/__/____

Staff COVID-19 Event Form

***VACCINATION STATUS**

Indicate the vaccination status of the staff member on the event date or date of specimen collection.

Has the staff member received any COVID-19 vaccine? ☐ Yes ☐ No

Which vaccine was received (select all that apply)?

- ☐ Pfizer-BioNTech
- ☐ Moderna
- ☐ Johnson & Johnson's Janssen
- ☐ Unspecified

****PRIMARY SERIES**

Indicate the date(s) for each vaccine received.

****Dose 1** Date: _____(MM/DD/YYYY)

****Dose 2** Date: _____ (MM/DD/YYYY) ☐ Not received

****ADDITIONAL OR BOOSTER DOSES**

Indicate the date(s) for any additional or booster doses of vaccine received.

*Has the staff member received any **additional or booster doses** of vaccine? ☐ Yes ☐ No

Date: _____ (MM/DD/YYYY) Date: _____ (MM/DD/YYYY) Date: _____ (MM/DD/YYYY)

***COVID-19 DEATH**

Did the staff member die from COVID-19 related complications?

☐ Yes ☐ No

**Date of death __/__/____