Third Party Proof of Vaccination Form

Please print:

Title: _____ Name: _____
(FIRST) (MIDDLE) (LAST)

REQUIRED: 3/4 ID or Last 4 SSN: _____ DOB (mm/dd/yy): _____/_____/_____

Company/Organization: _____

This statement affirms that I have been vaccinated with the most recently available seasonal influenza vaccine. I am submitting proof of vaccination with this form.

☐ Letter (on official letterhead) from a healthcare provider, pharmacy or clinic that issued the vaccination.

☐ Copy of immunization record showing my name as having received the vaccine.

☐ Other

I give permission to my employer to verify with the provider that I was administered the Influenza vaccine.

_____ _____

Signature of person receiving vaccine **Date**