UPMC | HORIZON UPMC | JAMESON

NON EMPLOYEE COVID VACCINATION ATTESTATION

First Name: _____

Last Name: _____

Middle Initial: _____

Email Address: _____

Date of Birth: MM/DD/YYYY _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: (_____) _____

Job Title: Volunteer

Department: Volunteer Services

What State did you get your vaccination in: _____

When did you receive your Dose 1 vaccine: Date_____

What was vaccine Dose 1 type?: []Pfizer [] Moderna {} Johnson & Johnson

I attest I have received Dose 1 of the COVID-19 vaccination at the following location

[] PCP [] Pharmacy [] UPMC [] Community Event [] Other _____

When did you receive your Dose 2 vaccine: Date _____

What was vaccine Dose 2 type?: []Pfizer [] Moderna {} Johnson & Johnson

I attest I have received Dose 2 of the COVID-19 vaccination at the following location

[] PCP [] Pharmacy [] UPMC [] Community Event [] Other _____

When did you receive your Dose 3 vaccine: Date_____

What was vaccine Dose 3 type?: []Pfizer [] Moderna {} Johnson & Johnson

I attest I have received Dose 3 of the COVID-19 vaccination at the following location

[] PCP [] Pharmacy [] UPMC [] Community Event [] Other _____

[] I attest that the response regarding my COVID-19 vaccination doses is correct and accurate to the best of my knowledge.

I understand and acknowledge that UPMC and its affiliated entities have reporting obligations and may be required to disclose information confirming my vaccine or exemption status in order to comply with local, state or federal regulations, or other applicable vaccine mandates. By selecting the "I accept terms" box below, I hereby authorize UPMC Benefit Management Services Inc. (UPMCBMS) to share the information I have provided herein and attested to above with UPMC's affiliated entities as applicable as part of UPMC's immunization registry program, as part of UPMC's wellness program, to evaluate any exemption requests, and/or to effectuate inclusion of my vaccination information into my UPMC electronic medical record. I further authorize UPMC to share information externally as necessary to comply with applicable vaccine mandates, or otherwise as is consistent with UPMC's privacy practice.

[] I accept the terms.

By selecting the "I accept term" box below, I hold harmless and forever discharge UPMCBMS, UPMC and their respective agents and affiliates from any and all claims, causes of action, and liabilities related to UPMCBMS' provision of the information I have submitted through this portal or UPMC's disclosure of the same information for the purposes stated herein.

[] I accept the terms.

Print Name: _____

Signature: _____

Date: _____