DOWNSTATE
HEALTH SCIENCES UNIVERSITY

TODAY'S DATE: _____

COVID-19 BIVALENT VACCINE ATTESTATION FORM

NAME: _____ CONTACT INFORMATION: _____

DEPARTMENT: _____ TITLE: _____

I HAVE **NOT RECEIVED A COVID-19 BIVALENT VACCINE**
FROM **OCTOBER, 2023 TO PRESENT** **Please check box** ☐

I HAVE RECEIVED A COVID-19 BIVALENT VACCINE

FROM OCTOBER, 2023 TO PRESENT

PLEASE PROVIDE:

VACCINATION DATE (MONTH/YEAR): _____

MANUFACTURER: _____