



**State of Delaware
Department of Human Resources**

COVID-19 VACCINATION CERTIFICATION FORM

Form #: COVID-19 Temporary Statewide Form	Authority: State of Delaware Declaration of a Public Health Emergency July 12, 2021; 20 Del. C. Chapter 3137
Effective: September 1, 2021	Supersedes: N/A

Employee Name: _____ Employee ID: _____

Department: _____

Division/Section: _____

I certify that I am fully vaccinated against COVID-19.

Note: Fully vaccinated is defined as two weeks following a single-dose vaccine or two weeks following the 2nd dose of a two-dose vaccine.

IF YOU HAVE NOT BEEN FULLY VACCINATED, YOU ARE REQUIRED TO UNDERGO WEEKLY TESTING FOR COVID-19 AND COMPLETE THE COVID-19 TESTING CERTIFICATION PROCESS WEEKLY.

Vaccine Manufacturer:

Johnson & Johnson Moderna Pfizer Other: _____

Date(s) of Dose(s): 1st dose: _____ 2nd dose: _____

I understand that the State is seeking my COVID-19 vaccination status in order to ensure that my workplace maintains an acceptable health and safety standard for my co-workers and visitors to the State's workspace, that I am required to provide accurate information in response to the questions above, and that failure to do so may result in disciplinary action. I certify that I have accurately and truthfully answered the questions above.

I understand that the Department of Human Resources may request documentation of my vaccination status (e.g. a copy of my vaccine card, immunization record). I understand that failure to provide documentation of full vaccination status upon request may result in disciplinary action.

I understand that any additional documentation or other confirmation of vaccination provided by me to my employer (the State of Delaware) is considered medical information and will be kept in a confidential medical file.

By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A party's electronic signature for purposes of the Uniform Electronic Transactions Act, 6 Del. C. Ch. 12A, may be provided by electronic initials or name, or e-mail confirmation. Authorizations provided on this form will expire one (1) year from the date submitted.

Employee Signature

Date

PLEASE SUBMIT COMPLETED FORM TO CovidCert@delaware.gov

PLEASE DO NOT INCLUDE VACCINATION CARD OR OTHER VACCINATION RECORDS UNLESS REQUESTED.

This policy is not intended to create any individual right or cause of action not already existing and recognized under State and Federal law.