COVID-19 Vaccination Status - Voluntary Declaration

Manitoba

Full Name: _____ Employee Number: _____

Position (List **ALL** positions held within the same health region/organization/employer):

_____

_____

_____

_____

*Individuals who hold a position in more than one health region/organization/employer must complete a form for each.

Employer: _____

Work Location: _____ Department/Unit: _____

Classification: _____

In preparation for the public health order that will be in effect by October 18, 2021, we are requiring you to complete the following disclosure form.

Choosing to provide your COVID-19 vaccination status is voluntary, and you may decline to disclose your vaccination status. However, any information you choose to provide must be accurate.

As of October 18, 2021, individuals who decline to disclose vaccination status or are not able to provide proof of full vaccination will be required to undergo regular testing for COVID-19. The information below will be used to help plan for the continuity of patient/resident/client care and services, staff scheduling and risk mitigation.

Fully vaccinated individuals have either received two doses (in any combination) of the AstraZeneca, Pfizer or Moderna vaccines, or a single dose of the Janssen/Johnson & Johnson vaccine, with more than 14 days having passed since the last dose. Acceptable forms of proof include the Manitoba Immunization Card (digital or physical).

Please select the statement below that accurately describes your vaccination status:

☐ I am fully vaccinated ☐ I am partially vaccinated Date of first dose _____

☐ I am not vaccinated/do not plan to be vaccinated ☐ I decline to disclose my vaccination status

I understand that I am required to provide accurate information in response to the question above. I hereby affirm that I have accurately and truthfully answered the question above. I also understand that if I stated that I am fully vaccinated, I will provide my employer the documentation of my vaccination status (e.g., an official document confirming vaccination status). Information will be retained in accordance with policies governing storage and access to personal health information.

PLEASE RETURN THIS FORM TO YOUR MANAGER/DESIGNATE
***For those who disclose fully vaccinated status, your manager/designate will be in contact to validate your proof of vaccination**

I understand that this information is confidential and will be treated as such by my employer in accordance with applicable legislation. The information will only be maintained so long as it is required. If you have any questions or concerns, you may speak with your HR representative, your manager, your Occupational Health Nurse (as applicable), or your union.

In the event your vaccination status changes, we ask that you submit an updated disclosure form. These forms are available from your manager.

Date: _____ Employee Signature: _____

Manager or delegate have seen and verified the proof of vaccination. This will be used as an alternative to submitting a copy of vaccination proof along with the completed declaration form. If the manager or delegate attests to seeing the proof, a copy does not need to be submitted along with the declaration form.

Date: _____ Manager Signature: _____

FOR OFFICE USE ONLY:

Vaccine status verified by (print name): _____

Type of documentation provided:

☐ QR Code (preferred) ☐ Other (specify) _____

Based on voluntary disclosure, is a plan for testing required:

☐ Yes ☐ No Signature of verifier: _____ Date: _____