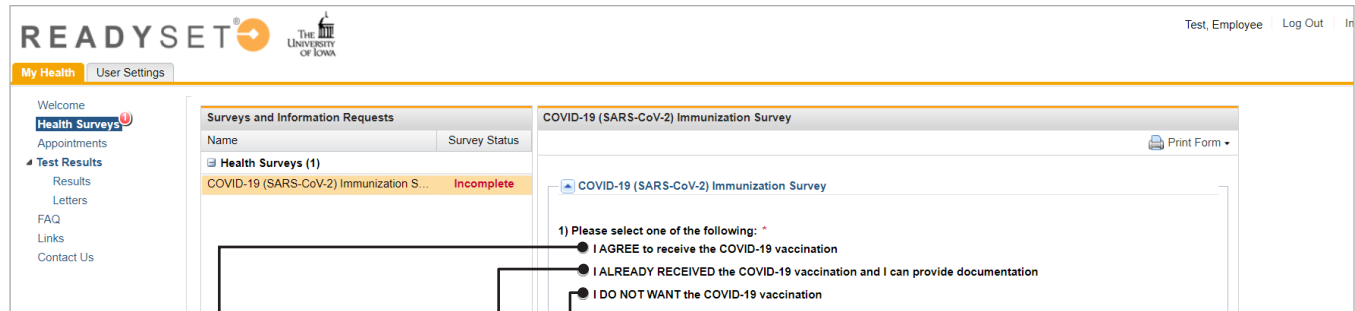


TAKING THE COVID-19 IMMUNIZATION SURVEY

Before you participate in the COVID-19 immunization program, you need to answer some questions. Log in to ReadySet, and...

1. Choose **Health Surveys** from the left menu
2. Choose **COVID-19 Immunization Survey** from the survey menu
3. Select **I AGREE** to receive, or **I ALREADY RECEIVED**, or **I DO NOT WANT** the COVID-19 vaccine



I AGREE TO RECEIVE AT UIHC

1. Read and acknowledge the **vaccine statement**
2. Answer the rest of the questions
3. Type your **Electronic Signature**
4. Choose **Submit Final**

COVID-19 - Receive Vaccination

You are required to review and acknowledge that you have read the CDC Vaccine Information Statement (VIS).
Please click here to view the Pfizer-BioNTech COVID-19 Vaccine Information Statement.

2) I hereby certify that I have read the COVID-19 Vaccine Information Statement. *

Yes

3) Please indicate your age range: *

Under 16

16 to 49

50 to 64

65 or older

6) Do you have any of the following chronic illnesses? *

Asthma, cancer, chronic liver disease, chronic lung disease, heart disease, diabetes, kidney dysfunction.

Yes

No

7) Do you have current or planned immunosuppression? *

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone =15 mg/day for =1 month) or other immunosuppressive medication

Yes

No

8) Do you have a bleeding disorder (such as hemophilia, low platelets) or are you taking a blood thinner? *

Yes

No

COVID-19 - Acknowledgement to Receive Vaccination

35) I consent to having my immunization information shared with the state registry. *

Yes

No

36) I consent to having my immunization information shared with my personal Electronic Health Record. *

Yes

No

37) I want to receive the COVID-19 vaccination. I hereby certify that I have carefully read this COVID-19 (SARS-CoV-2) Immunization Survey, that I understand it and that the information given is complete, true and accurate to the best of my knowledge. I understand that the falsification or misrepresentation of any of the information, or the failure or neglect to disclose any of the information may be grounds for termination from this program, regardless of when such falsification, misrepresentation, failure or neglect may be discovered. TYPE YOUR NAME BELOW. THIS CONSTITUTES AN ELECTRONIC SIGNATURE THAT IS REQUIRED BY LAW.

I ALREADY RECEIVED

1. Indicate **when and where** you received your vaccine
2. Type your **Electronic Signature**
3. Choose **Submit Final**

13) Have you had a previous adverse reaction to any COVID-19 vaccine? *

Yes

No

Not applicable

COVID-19 - Vaccination Received Elsewhere

27) When did you receive your COVID-19 vaccination? (Month/Year) *

Previous employer

Personal physician

Walk-in clinic

Pharmacy

Other location

28) Where did you receive your COVID-19 vaccination? *

29) If other location, please indicate where you received your COVID-19 vaccination.

30) I received the COVID-19 vaccination elsewhere. I hereby certify that I have carefully read this COVID-19 (SARS-CoV-2) Immunization Survey, that I understand it and that the information given is complete, true and accurate to the best of my knowledge. I understand that the falsification or misrepresentation of any of the information, or the failure or neglect to disclose any of the information may be grounds for termination from this program, regardless of when such falsification, misrepresentation, failure or neglect may be discovered. TYPE YOUR NAME BELOW. THIS CONSTITUTES AN ELECTRONIC SIGNATURE THAT IS REQUIRED BY LAW.

I DO NOT WANT

1. Indicate **why you do not want** the vaccine
2. Type your **Electronic Signature**
3. Choose **Submit Final**

I do not want to receive the COVID-19 vaccine. I acknowledge that COVID-19 vaccination is recommended by the Centers for Disease Control and Prevention (CDC) for all healthcare personnel to prevent infection from and transmission of SARS-CoV-2 and its complications, including death, to my patients, my coworkers, my family, and my community. By selecting this option, I understand that if my workplace has a mandatory vaccination program, I am requesting an exemption.

31) I agree and accept the above statement. *

Yes

No

32) I have a medical condition that prevents me from receiving the COVID-19 vaccine. *

Yes

No

33) I do not believe in vaccines for religious reasons. *

Yes

No

34) I do not want to receive the COVID-19 vaccination. I hereby certify that I have carefully read this COVID-19 (SARS-CoV-2) Immunization Survey, that I understand it and that the information given is complete, true and accurate to the best of my knowledge. I understand that the falsification or misrepresentation of any of the information, or the failure or neglect to disclose any of the information may be grounds for termination from this program, regardless of when such falsification, misrepresentation, failure or neglect may be discovered. TYPE YOUR NAME BELOW. THIS CONSTITUTES AN ELECTRONIC SIGNATURE THAT IS REQUIRED BY LAW.

Reset Save Draft Submit Final