

Organizational Health Information Request Form

Personal Information

Full Name: _____

Date of Birth (DD/MM/YYYY): _____

Employee ID Number: _____

Department: _____

Email Address: _____

Immunization Records Request (check all that apply)

COVID-19

Influenza -

MMR (Measles, Mumps, Rubella)

Varicella (Chickenpox)

Tdap (Tetanus/Diphtheria/Pertussis)

Hepatitis B

N95 Mask Fit Test

Violence Prevention Certificate

****Employees must submit requests a minimum of 48 hours in advance for delivery on Fridays. Requests received with less than 48 hours' notice will be fulfilled the following Friday.**

I consent to the release of this information to the above documented email for health and safety purposes.

Signature: _____

Date: _____