



DOCUMENTATION OF 2023-2024 COVID VACCINATION

Please complete this form if you received your 2023-2024 COVID vaccination at a facility other than McLaren Employee Health. Date administered and LOT number are required fields. Print legibly please. Difficult to read documents will not be entered.

Name (printed): _____ DOB: _____

EEID #: _____ Social Security Number: xxx-xx-_____

McLaren Facility Location: _____ Department: _____

Please Check One: Employee Non-Employed Provider
 Contractor Volunteer/Student

THIS SECTION MUST BE COMPLETED BY THE HEALTHCARE PROVIDER ADMINISTERING THE VACCINE

2023-24 COVID Vaccine

Manufacturer (Check One): Pfizer Moderna

_____ / ____ / ____
 Lot Number Expiration Date

 Healthcare Provider printed name Healthcare Provider signature Date Received

 Clinic Name

PLEASE RETURN THIS FORM TO YOUR LOCAL EMPLOYEE HEALTH DEPARTMENT OR SCAN AND EMAIL TO employee.health@McLaren.org