

Department of Health and Social Services

Division of Public Health Director's Office

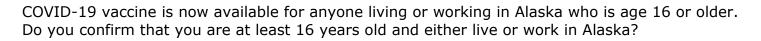
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COVID Vaccine Provider Attestation Form

As a COVID Vaccine Provider, I agree to confirm each vaccine recipient's eligibility to receive the vaccine based on the requirements provided by the State of Alaska. The State of Alaska has provided me with an Eligibility Script to assist in screening efforts. I will review the eligibility requirements with each vaccine recipient and confirm their eligibility. I acknowledge that I may no longer be able to provide COVID vaccine if I do not adhere to this requirement.

rganization name:
inted name:
anature & Date:

Suggested Eligibility Script



Note to clinician: If a person does not answer yes to the above question, they are not eligible to receive the COVID-19 vaccine yet.