

Optional Person-Level Reporting of Weekly COVID-19 Vaccination for Healthcare Personnel (57.217, Rev 3)

(Note: This form is used for the Healthcare Personnel Safety and Long-term Care Facility Components.)

Page 1 of 1

*Required for saving **conditionally required

Person-Level COVID-19 Vaccination Form for Healthcare Personnel – HPS and LTCF Components

Facility ID*:	
Vaccine Location Type ^{a*} : <input type="checkbox"/> VACCHOSP <input type="checkbox"/> VACCIPF <input type="checkbox"/> VACCIRF	HCP Category*: <input type="checkbox"/> Employees <input type="checkbox"/> Licensed independent practitioners <input type="checkbox"/> Volunteers <input type="checkbox"/> Other Contract Personnel
Unique HCP ID*:	First Name*:
Middle Name (optional):	Last Name*:
Date of Birth*:	Sex*: <input type="checkbox"/> F (Female) or <input type="checkbox"/> M (Male) or <input type="checkbox"/> N (Missing) Note: Select "N (Missing)" only if a value of F or M is not available in the medical record.
Race* (Select all that apply): <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to respond <input type="checkbox"/> Unknown	Ethnicity* (Specify): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Not Latino <input type="checkbox"/> Declined to respond <input type="checkbox"/> Unknown
Employee Start Date*:	Employee End Date:

Vaccination History

Vaccination Type*:	Not Vaccinated: Reason**:	Vaccine Date*:	Dose Type*:	Vaccination Expiration Date:	NDC Number:
<input type="checkbox"/> COVID-19	<input type="checkbox"/> Medical Contraindications <input type="checkbox"/> Declinations <input type="checkbox"/> Unknown <input type="checkbox"/> Other				Vaccine Lot Number:

^aVaccine Location Type Field is only required by users of the HPS component and does not apply to users of the LTCF component.

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d))

Public reporting burden of this collection of information is estimated to average 61 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS H21-8, Atlanta, GA 30333, ATTN: PRA (0920-1317). CDC 57.217, v.3 January 2026