# Please complete the form below if you have received both COVID-19 vaccination doses.

|  |  |
| --- | --- |
| **Full Name** |  |
| **Payroll ID** |  |
| **Relationship with Mater** | [   ] Mater staff[   ] VMO[   ] Contractor[   ] Student[   ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Date of your first COVID-19 vaccine (dd/mm/yyyy)** |  |
| **Type of your first COVID-19 vaccine** | [   ] Moderna[   ] Pfizer Comimaty[   ] Vaxzevria (AstraZenica) |
| **Date of your second COVID-19 vaccine (dd/mm/yyyy)** |  |
| **Type of your second COVID-19 vaccine** | [   ] Moderna[   ] Pfizer Comimaty[   ] Vaxzevria (AstraZenica) |
| **Attachment (Proof of Vaccination)** | [   ] Yes |

# Please return this form to Covid.Vaccination.Register@mater.org.au