# Please complete the form below if you have received your first COVID-19 vaccination dose.

|  |  |
| --- | --- |
| **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 you expect to get your second COVID-19 vaccine (dd/mm/yyyy)** |  |

# Please return this form to [Covid.Vaccination.Register@mater.org.au](mailto:Covid.Vaccination.Register@mater.org.au)