			Official Certification by Vaccination Provider (
COVID-19 vaccine (			

Personal Details (please print)

Surname		Given name:	
Date of Birth		Staff/student ID	
Contact	Mobile:	Work:	

[illegible]	**[illegible]**	**[illegible]**	**Official Certification by Vaccination Provider**
Influenza vaccine [illegible]			
TB Screening	**[illegible]**	**[illegible]**	**Assessed by/Given by/Read by**
[illegible]		☐ YES ☐ NO	
Past vaccination BCG		☐ YES ☐ NO	
Interferon Gamma Release Assay (IGRA) (circle test result)			
IGRA		Positive Indeterminate Negative	
IGRA		Positive Indeterminate Negative	
Tuberculin Skin Test (TST) – TB Service/Chest Clinic only			
TST Administration			
TST Reading		Induration mm	
TST Administration			
TST Reading		Induration mm	
Referral to = o = R Pervi ě oR			

INSTRUCTIONS

Enough information must be provided to enable an assessor to verify that an appropriate vaccine has been administered by a registered vaccination provider. Therefore:

- Providers should record their full name, signature, date specific vaccine given and official provider stamp at the time of vaccine administration.
- Batch numbers should be 020d015A02ls shatch nu[illegible] ů5[illegible] ů9[illegible] al (i)-75 (c)7u5 33.lh numbers should beoouo•a-8(l)2d1 (l)23.h nam(so(•