Eastern Band of Cherokee Indians Public Health and Human Services Division
&
Cherokee Indian Hospital Authority

VACCINE ATTESTATION FORM

Instructions: If not completing electronically, please print clearly. Submit this form via email along with your vaccine card/record to Covidvaccine@cherokeehospital.org or deliver to the patient registration desk at Cherokee Indian Hospital

I acknowledge that as a patient of Cherokee Indian Hospital Authority, I am responsible for ensuring that the information I am providing is accurate and true.

I attest that I have received a COVID-19 Vaccine and the vaccination card/record has not been falsified by myself, any organization, or other individuals.

I understand that if my vaccination card/record has been falsified, the Cherokee Indian Hospital Authority will remove my designation of "Vaccinated" from my medical record.

IF it is found that an individual has falsified any information to obtain winnings from Vax Cash promotion, that individual will forfeit all winnings.

Cherokee Indian Hospital Authority Patient Name: __________

Today's Date: __________

Date of Birth: __________

Address (Mailing): __________

Physical Address: __________

Location of Vaccination Site: __________

Telephone Number: __________

Health Record #: __________

By entering my full legal name in the space provided I am certifying the information provided in this form is true and accurate to the best of my knowledge:

Enter Full Legal Name: __________

Date: __________