



CLARENCE CENTRAL SCHOOL DISTRICT COVID-19 Verification of Vaccination Appointment

To be completed by employee:

(please print all information)

Name: _____ **Telephone:** _____

Address: _____

City/State/Zip: _____

Date of Birth: _____

To be completed by service provider:

This verifies that the above named individual appeared at:

(Name of Provider)

on: _____ at _____ a.m./p.m.
(Date) *(Time)*

Print Name: _____

Signature: _____

Please include a copy of your vaccination card.