ATTACHMENT 2
DD Form 3150 – "Certification of Vaccination"

CUI (when filled in)

CERTIFICATION OF VACCINATION	*OMB No. 0704-0613* *Expiration: 20220228*

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 2 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PRIVACY ACT STATEMENT

Authority: DoD is authorized to collect the information on this form pursuant to Executive Order (E.O.) 13991, Protecting the Federal Workforce and Requiring Mask-Wearing and E.O. 12196, Occupational Safety and Health Program for Federal Employees; as well as 10 U.S.C. 113, 10 U.S.C. 136, 10 U.S.C. 7013, 10 U.S.C. 8013, 10 U.S.C. 9013, 10 U.S.C. 2672, 5 U.S.C. chapters 11, and 79, and DoD Instruction 6200.03.

Principal Purpose: This information is being collected and maintained to implement Coronavirus Disease 2019 (COVID-19) workplace safety plans, including DoD's COVID-19 testing programs, and to ensure the safety and protection of the DoD workforce, workplace, and other DoD facilities and environments, consistent with the above-referenced authorities, the COVID-19 Workplace Safety: Agency Model Safety Principles established by the Safer Federal Workforce Task Force, and guidance from the Centers for Disease Control and Prevention and the Occupational Safety and Health Administration.

Routine Use(s): While the information requested on this form is intended to be used primarily for internal purposes, in certain circumstances it may be necessary to disclose this information externally, for example to disclose information to: a person, organization, or governmental entity as necessary and relevant to notify them of, respond to, or guard against a public health emergency or other similar crisis, including to comply with laws governing the reporting of communicable disease or other laws concerning health and safety in the work environment; adjudicative bodies (e.g., the Merit System Protection Board), arbitrators, and hearing examiners to the extent necessary to carry out their authorized duties regarding Federal employment; contractors, grantees, experts, consultants, students, and others as necessary to perform their duties for the Federal government; agencies, courts, and persons as necessary and relevant in the course of litigation, and as necessary and in accordance with requirements for law enforcement; or to a person authorized to act on your behalf. A complete list of routine uses may be found in the applicable System of Records Notice (SORN) associated with the collection of this information. For most Federal employees: OPM/GOVT-10, Employee Medical File System of Records, **75 Fed. Reg. 35099 (Jun. 21, 2010)**, amended **80 Fed. Reg. 74815 (Nov. 30, 2015)**. For Federal employees not covered by OPM/GOVT-10, contractor personnel, and other DoD-affiliated persons: DPR 39 DoD, DoD Personnel Accountability and Assessment System of Records,
85 Fed. Reg. 17047 (Mar. 26, 2020) (also available at https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/OSDJS/DPR-39-DoD.pdf).

Consequences of Failure to Provide Information: Providing this information is voluntary. However, if you fail to provide this information, you will be treated as not fully vaccinated for purposes of implementing safety measures, including with respect to mask-wearing, physical distancing, testing, travel, quarantine, and restrictions on access to DoD facilities and environments. Failure to provide such information may also hinder DoD's ability to implement COVID-19 workplace safety plans, thereby increasing the health or safety risk to DoD-affiliated personnel and DoD facilities.

INSTRUCTIONS: This form should be completed by civilian employees, onsite contractor employees, and other individuals if required in accordance with current DoD Force Health Protection Guidance. Service members should not complete this form.

1. NAME *(Last, First, MI)*:	**2. DoD ID NUMBER:**

3. PLEASE CHECK THE BOX BELOW THAT COINCIDES WITH YOUR COVID-19 VACCINATION STATUS :

☐ I am fully vaccinated.
Individuals are considered "fully vaccinated" two weeks after completing the second dose of a two-dose COVID-19 vaccine (e.g., Pfizer-BioNTech or Moderna) or two weeks after receiving a single dose of a one-dose vaccine (e.g., Johnson & Johnson/Janssen).

☐ I am not yet fully vaccinated. I received my first dose of Moderna or Pfizer and my second appointment is scheduled, or I received my final dose of any vaccine less than two weeks ago.

☐ I have not been vaccinated.

☐ I decline to respond.

Individuals who choose not to complete the form will be assumed to be not fully vaccinated for purposes of application of the safety protocols. If you are not vaccinated due to medical or religious reasons, please check either "I have not been vaccinated" or "I decline to respond." Note that if you have already received one dose of a vaccine, but are not yet fully vaccinated, or if you received your final dose less than two weeks ago, then you will be treated as not fully vaccinated until you are at least two weeks past your final dose and resubmit your vaccination information.

☐ I attest that the information provided in this form is accurate and true to the best of my knowledge.

I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both (18 U.S.C. 1001). Checking "I decline to respond" does not constitute a false statement. I understand that making a false statement on this form could result in additional administrative action including an adverse personnel action up to and including removal from my position.

4. DATE *(YYYYMMDD)*	**5. SIGNATURE *(Full Name)***

Controlled by: OUSD(P&R)
Controlled by: ASD(HA)
CUI Category: HLTH: PRVCY; OPSEC
LDC: DL(DoD Only)
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