

**Purchase College State University of New York
Covid 19 Vaccination Leave Form**

To be completed by employee (Please Type or Print)

Employee Name:

Date of Vaccination:

**First dose _____ Second Dose _____
(If applicable)**

**Time Away From Work:
(Include Travel Time)**

This is to certify that the above individual received a vaccination today:

X _____ Date _____

Signature of Individual administering the vaccination

***Please submit the completed form to the Department of Human Resources to
the attention of Susan Ciliberti**