COVID-19 Vaccination Organization /Agency Interest Form
Fax Completed Form to: Public Health at 503-842-3983

Agency Name:	**Date:**
Contact Person:	
Contact Phone:	**Contact email:**

Total employee count: _____ **Total employees requesting vaccination:_____**

Agencies and Organizations are eligible under the following Phase 1 group (check one):

This form is not for individual use. Please check with your organization or agency prior to completing.

☐ **Group 1:** hospitals; urgent care; skilled nursing and memory care facility HCP and residents; tribal health programs; EMS providers and other first responders ***(specify)*** _____

☐ **Group 2:** other LTCFs and congregate care sites including HCP and residents; hospice programs; mobile crisis care and related services; secure transport; individuals working in a correctional setting

☐ **Group 3:** outpatient settings serving specific high-risk groups; in home care; day treatment services; non-emergency medical transport (NEMT)

☐ **Group 4:** all other outpatient; public health and early learning sites; death care workers

☐ **Group 5:** School Staff

(optional) **List individuals in your organization/ agency who have expressed interest in receiving the COVID-19 vaccination.**

Name, Optional *(type or print)*	Name, Optional *(type or print)*
1.	16.
2.	17.
3.	18.
4.	19.
5.	20.
6.	21.
7.	22.
8.	23.
9.	24.
10.	25.
11.	26.
12.	27.
13.	28.
14.	29.
15.	30.

**This list will be used for vaccine planning and coordination purposes only. Additional information will be communicated with the agency contact person as vaccines become available to each group.*