

The 'COVID-19 Vaccine Declaration' form is accessible in MedAccess EMR. Please use this form to pre-register for your COVID-19 vaccine. Please also indicate if you are willing to become a COVID-19 Immunizer and hold COVID-19 vaccination clinics in your area of practice (if applicable).

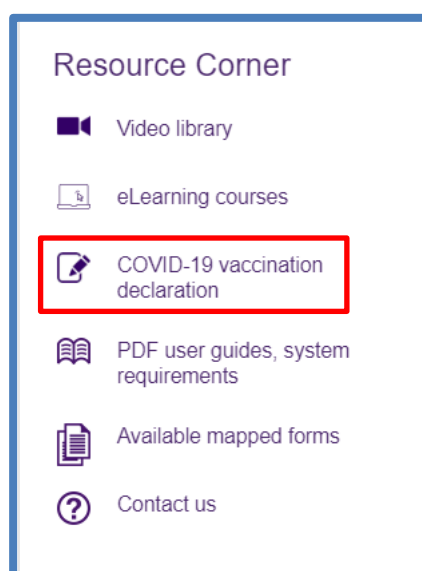
Accessing the COVID-19 Vaccination Declaration Form

To access the 'COVID-19 Vaccination Declaration' form, complete the following steps:

- Login to MedAccess EMR.
- From the landing page or day sheet, click the **Help** icon located in the top right corner of the screen.



- Click **COVID-19 vaccination declaration** from the left side of the screen under Resource Corner.



Filling Out the Form

In order for Public Health Representatives to plan for future vaccine clinics, please indicate whether you are a **Physician** or **Pharmacist** from the drop-down menu.

The COVID-19 Vaccine Declaration is intended for Physicians and Pharmacists. This form will notify Public Health of those Physicians and Pharmacists who are interested in becoming COVID-19 immunizers and who are interested in receiving the COVID-19 vaccine. Please complete this form to indicate your intent to participate in the continued deployment of the Provincial COVID-19 vaccination plan.

Occupation Type

Select...
Physician
Pharmacist

Support

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Proceed to fill in the following demographic details and other pertinent information. For timely processing, ensure that all the information on the form is accurate. Once your information is provided, click the **Submit** button at the bottom of the screen.

Once submitted, this form will be sent to Public Health to begin the next phase of planning for the continued deployment of the Provincial COVID-19 vaccination plan.

Physician:

The COVID-19 Vaccine Declaration is intended for Physicians and Pharmacists. This form will notify Public Health of those Physicians and Pharmacists who are interested in becoming COVID-19 immunizers and who are interested in receiving the COVID-19 vaccine. Please complete this form to indicate your intent to participate in the continued deployment of the Provincial COVID-19 vaccination plan.

Occupation Type
Physician

Information

First Name
Last Name
Middle Initial (Optional)

Date of Birth
MCP (Format: 123456789123)
MCP

License Number
Medical Clinic Name
Speciality (Optional)

Phone Number
Phone Number Type
Regional Health Authority

Email Address
Confirm Email Address

Address Line (Street)
City/Town
Province

Country
Postal Code (ASBAG9)

Questions

Are you a Fee-for-Service or Salaried Physician?
Are you interested in being a COVID-19 immunizer?
Did you receive your first dose of the COVID-19 Vaccine?
Will you hold COVID-19 vaccine clinics at your practice?
Are you a MedAccess EMR user?

I acknowledge and understand that with the submission of this form the Department of Health and Community Services or Public Health in your Regional Health Authority will contact you regarding the COVID-19 vaccination process.

Submit

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Pharmacist:



The COVID-19 Vaccine Declaration is intended for Physicians and Pharmacists. This form will notify Public Health of those Physicians and Pharmacists who are interested in becoming COVID-19 immunizers and who are interested in receiving the COVID-19 vaccine. Please complete this form to indicate your intent to participate in the continued deployment of the Provincial COVID-19 vaccination plan.

Occupation Type
Pharmacist

Information

First Name <input type="text"/>	Last Name <input type="text"/>	Middle Initial (Optional) <input type="text"/>
Date of Birth Year <input type="text"/> Month <input type="text"/> Day <input type="text"/>	MCP (Format: 123456789123) <input type="text"/>	
Registration Number <input type="text"/>	Pharmacy Name <input type="text"/>	
Phone Number <input type="text"/>	Phone Number Type <input type="text"/>	Regional Health Authority <input type="text"/>
Email Address <input type="text"/>	Confirm Email Address <input type="text"/>	<input type="text"/>
Address Line (Street) <input type="text"/>	City/Town <input type="text"/>	Province <input type="text"/>
Country <input type="text"/>	Postal Code (A8A8A8) <input type="text"/>	<input type="text"/>

Questions

Are you interested in being a COVID19 immunizer?

Do you want to receive the COVID-19 vaccine?

I acknowledge and understand that with the submission of this form the Department of Health and Community Services or Public Health in your Regional Health Authority will contact you regarding the COVID-19 vaccination process.

[Support](#)

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