Name: (please print) Date:

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I hereby declare the following: (please check all boxes)

I understand that taking the COVID-19 vaccine is not a condition of my employment.

I am fully and personally responsible for my own safety and actions while and during my participation.

With full knowledge of the risks involved, I hereby release, waive, discharge the Organization, its board, officers, independent contractors, affiliates, employees, representatives, successors, and assigns from any and all liabilities, claims, demands, actions, and causes of action whatsoever, directly or indirectly arising out of or related to any loss, damage, injury, or death, that may be sustained by me related to COVID-19 while participating in any activity while in, on, or around the premises or while using the facilities that may lead to unintentional exposure or harm due to COVID-19.

I agree to indemnify, defend, and hold harmless the Organization from and against any and all costs, expenses, damages, lawsuits, and/or liabilities or claims arising whether directly or indirectly from or related to any and all claims made by or against any of the released party due to injury, loss, or death from or related to COVID-19.

Completing this form does not guarantee receiving a vaccine, it is merely to express interest in receiving a vaccine should one be available.

The vaccine provider may want you to fill out a medical history form. You can review the form prior to receiving the vaccine at: <https://www.arrx.org/covid-vaccine> (Form Name: Provider Universal COVID-19 Patient Consent Form) Do not give this form to your bank, it is for Pharmacy use only.

Signature: Date:

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\*This is a sample form only, it is not legal advice.