Name of health care provider:
Health care provider code:
Name of physician:
Code of physician:

Certificate of vaccination against COVID 19 for a patient– second vaccination

Name, surname and degree of a patient:

Health Insurance Company code:

Personal (ID) number:

Date and time of vaccination:

Report of examination:

- anamnestic questionnaire and examination: completed / incompleted (strike out where applicable)
- manufacturer:
- name of vaccine:
- State Institute for Drug Control code:
- batch:

Stamp of the medical facility: