

GO TO

www.impacthealth.com/rpafp

AND CLICK ON REGISTER
UNDER NEW PARTICIPANTS

Welcome to the COVID-19 Vaccination portal!

Schedule a vaccination appointment.



Returning Users

Sign in below.

Username

[Forgot username?](#)

Password

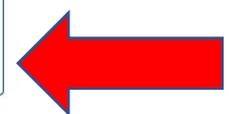
[Forgot password?](#)

Log on

New Participants

Every individual that is registering for a test must create a separate account.

Register



If you are having trouble logging in, please contact customer support at 515-442-8353 between 8 am - 5 pm CST.

SIGN THE ELECTRONIC HIPPA CONSENT BY CLICKING ACCEPT

Terms and Conditions

Participant Informed Consent:

I certify that I am: (a) the patient and at least 18 years of age; or (b) the parent or legal guardian of the patient and confirm that the patient is at least 5 years of age; or (c) authorized to consent for vaccination for the participant named below. Further, I hereby voluntarily give my consent to Impact Health Biometric Testing, Inc. and its agents to administer the COVID-19 vaccine to me.

I wish to participate in today's Vaccination program, which is being conducted by Impact Health Biometric Testing, Inc. This single Consent is granted for all necessary injections in order to affect the immunization in accordance with each manufacturer's guidelines and that my continued presentment and participation in the vaccination program constitutes my timely intent and consent to be vaccinated.

I understand that while some vaccines have been FDA approved, certain COVID-19 vaccines have not been approved or licensed by the FDA, but have been authorized for emergency use by FDA, under an Emergency Use Authorization (EUA). For individuals 5 years of age and older (Pfizer); or, 18 years of age and older (Moderna); or, 18 years of age and older (J&J). The emergency uses of these vaccinations are authorized for the limited duration of the emergency justifying the EUA under Section 564(b)(1) of the FD&C Act, unless the declaration is otherwise terminated, or authorization revoked sooner. I confirm that the patient meets the age requirements above in order to receive the COVID-19 vaccine being offered today.

I understand and acknowledge that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I further understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet for the COVID-19 vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that I have been advised to remain in the post-vaccination observation area for approximately 15-30 minutes after vaccine administration for observation. I understand that if I experience a severe reaction, I will notify onsite staff immediately. If the severe reaction occurs after I have left the location where I received my vaccination, if necessary, I will call 9-1-1 or go to the nearest emergency department for treatment.

I understand I will be required to provide personal information requested for the purpose of properly documenting vaccine screening and for vaccine administration.

I understand that the vaccine requires inserting a needle into my upper arm or thigh, which may result in some discomfort.

If I am pregnant and/or undergoing fertility treatment, I have discussed receiving the COVID-19 vaccine with my treating provider, having had my questions answered to my satisfaction, and have been approved to receive the COVID-19 vaccine.

If I am immunocompromised, I have discussed receiving the COVID-19 vaccine with my treating provider, having had my questions answered to my satisfaction, and have been approved to receive the COVID-19 vaccine.

I understand that in order to assure that my personal medical record reflects the receipt of the COVID-19 vaccine, confirmation of this vaccine will be documented in my personal medical record by Impact Health Biometric Testing, Inc. and, in compliance with immunization reporting requirements, with the state's immunization information system.

I acknowledge that the transmission and receipt of information during or after receiving my vaccination, including any communication via the internet or e-mail, does not constitute or create a doctor-patient or other healthcare professional relationship between me and Impact Health or any other entity involved in this vaccination program.

I, my heirs, assigns, agents, and personal representatives, waive and release Impact Health Biometric Testing, Inc. and all persons participating with Impact Health Biometric Testing, Inc. in connection with this program, and their subsidiaries, affiliates and parent corporations and their respective officers, directors, agents or employees, from any and all claims, demands or causes of action for damages or injuries that I may have or later acquire against Impact Health Biometric Testing, Inc. or such other entities resulting from or arising out of my participation in this vaccination program, including my presence at the vaccination site, any services or communications provided in connection with this vaccination program.

I understand and expressly consent that the information provided on this form and my responses to the questionnaire ("my Personal Information") may be used or disclosed by Impact Health Biometric Testing, Inc. without notice to me in any manner permitted or required by state or federal law or regulation or relevant public authority. Under no circumstances shall your personal information be disclosed to any third party for marketing purposes or without lawful purpose.

I further authorize the Department of Health (DOH) or its agents or assigns to submit a claim to my insurance provider, or Medicare Part B, without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.

I understand that this Informed Consent Form will be executed through the use of an electronic click assent, the use of which, expressly indicates my intent to execute this document in accordance with the Electronic Signatures in Global and National Commerce Act (E-Sign Act), Title 15, United States Code, Sections 7001 et seq., the Uniform Electronic Transaction Act (UETA), and any applicable state law, and that any electronic click assent will be deemed an original signature for purposes of this Authorization, with such electronic click assent having the same legal effect as an original signature.

I HAVE CAREFULLY READ THIS INFORMED CONSENT FORM AND FULLY UNDERSTAND AND AGREE WITH ITS CONTENTS. I EXPRESSLY CONSENT TO THE USE OF ELECTRONIC CLICK ASSENT AND UNDERSTAND THAT BY CLICKING "I AGREE," I HAVE AFFIRMATIVELY EXECUTED THIS INFORMED CONSENT FORM AS IF I HAD PROVIDED AN ORIGINAL SIGNATURE ON THIS DOCUMENT.



Accept

Decline



COMPLETE THE FOLLOWING INFORMATION. IF YOU ARE A PARENT/GUARDIAN FILLING THIS OUT, PLEASE PUT THE PARTICIPANTS INFORMATION HERE. (YOU CAN USE THE SAME EMAIL FOR MULTIPLE PARTICIPANTS) CLICK REGISTER TO PROCEED TO NEXT PAGE

New User Registration

Complete the following information.

Gender Male Female Not specified

Date of birth

First name

Last name

E-mail address

Confirm e-mail

Telephone no

Address

City

State

ZIP



CREATE A USERNAME AND
PASSWORD, PLEASE KEEP
THIS IN A SAFE PLACE IN
THE EVENT YOU NEED TO
LOG BACK INTO THE
PORTAL TO CANCEL OR
CHANGE YOUR
APPOINTMENT.EACH
PARTICIPANT MUST HAVE
THEIR OWN
USERNAME(YOU CAN NOT
USE THE SAME USERNAME
FOR MORE THAN 1
PARTICIPANT)

Set Username/Password

Your registration request has been accepted and you now need to choose a username and password that you will need to enter each time you return to the site. Please enter the username and password you would like to use and click on 'Sign in' to enter the site. Your registration is not complete until you have chosen your username and password.

- Password must include both upper and lower case letters.
- Password must include at least one number.
- Password must be at least 6 characters long.
- Previous 7 passwords cannot be reused.

Username

Password

Confirm
password



Sign in

Cancel

SIGN THE ELECTRONIC INFORMED CONSENT BY CLICKING ACCEPT

Terms and Conditions

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I certify that I am: (a) the patient and at least 18 years of age; or (b) the parent or legal guardian of the patient and confirm that the patient is at least 5 years of age; or (c) authorized to consent for vaccination for the participant named below. Further, I hereby voluntarily give my consent to Impact Health Biometric Testing, Inc. and its agents to administer the COVID-19 vaccine to me.

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I acknowledge that the transmission and receipt of information during or after receiving my vaccination, including any communication via the internet or e-mail, does not constitute or create a doctor-patient or other healthcare professional relationship between me and Impact Health or any other entity involved in this vaccination program.

I, my heirs, assigns, agents, and personal representatives, waive and release Impact Health Biometric Testing, Inc. and all persons participating with Impact Health Biometric Testing, Inc. in connection with this program, and their subsidiaries, affiliates and parent corporations and their respective officers, directors, agents or employees, from any and all claims, demands or causes of action for damages or injuries that I may have or later acquire against Impact Health Biometric Testing, Inc. or such other entities resulting from or arising out of my participation in this vaccination program, including my presence at the vaccination site, any services or communications provided in connection with this vaccination program.

I understand and expressly consent that the information provided on this form and my responses to the questionnaire ("my Personal Information") may be used or disclosed by Impact Health Biometric Testing, Inc. without notice to me in any manner permitted or required by state or federal law or regulation or relevant public authority. Under no circumstances shall your personal information be disclosed to any third party for marketing purposes or without lawful purpose.

I further authorize the Department of Health (DOH) or its agents or assigns to submit a claim to my insurance provider, or Medicare Part B, without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.

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Accept

Decline

FILL OUT THE INFORMATION
HERE AND CLICK NEXT

VIEW THE EUA FACT SHEET
HERE

VIEW FREQUENTLY ASKED
QUESTIONS AND EUA FACT
SHEET HERE



COVID-19 Vaccination ^

Schedule a Vaccination

To schedule a vaccination appointment, please select from the following options.

- I have not been vaccinated against COVID-19 and would like to schedule a first dose
- I have had one dose of the Pfizer or Moderna vaccine and would like to schedule a second dose
- I have had two doses of the Pfizer or Moderna vaccine and would like to schedule an additional immunocompromised dose
- I have had 2 doses of the Pfizer or Moderna vaccine and would like to schedule a booster dose
- I have had one dose of the Janssen vaccine and would like to schedule a booster dose.



Next

Pfizer EUA fact sheet ^



Prior to vaccinating, please review the Pfizer EUA Patient Fact Sheet below.

- [Pfizer Vaccine Patient Fact Sheet](#)
- [Hoja informativa para el paciente sobre la vacuna Pfizer](#)
- [Pediatric Pfizer Vaccine Patient Fact Sheet](#)

FAQ's ^



Click below to find the CDC's answers to commonly asked questions about COVID-19 vaccination.

- [CDC Frequently Asked Questions about COVID-19 Vaccination](#)

V-Safe Information Sheet ^

v-safe is the after vaccination health checker!

- [CDC V-Safe Information Sheet](#)

FILL OUT THE
NEXT SET OF
QUESTIONS
AND CLICK
NEXT

COVID-19 Vaccination

Are you feeling sick today? Any Fever >100.4 F, Cough, shortness of breath, difficulty breathing, fatigue, chills, repeated shaking with chills, muscle aches, headache, sore throat, congestion or runny nose, nausea, vomiting, diarrhea, or a new loss of taste and smell **beyond your normal experience**?

Yes No

In the last 10 days, have you had a COVID-19 Positive test or been told by a healthcare provider or the health department to isolate or quarantine at home due to COVID-19 infection or exposure?

Yes No

Have you ever had a severe allergic reaction (e.g., anaphylaxis) to a previous dose of a COVID-19 vaccine?

Yes No

Have you been treated with monoclonal antibody therapy for COVID-19 in the past 90 days (3 months)?

Yes No

Pfizer EUA fact sheet

Prior to vaccinating, please review the Pfizer EUA Patient Fact Sheet below.



- Pfizer Vaccine Patient Fact Sheet
- Hoja informativa para el paciente sobre la vacuna Pfizer
- Pediatric Pfizer Vaccine Patient Fact Sheet

FAQ's

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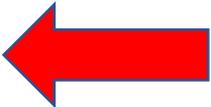


- CDC Frequently Asked Questions about COVID-19 Vaccination

V-Safe Information Sheet

v-safe is the after vaccination health checker!

- CDC V-Safe Information Sheet



FILL OUT THE FOLLOWING HEALTH SCREENING QUESTIONS AND CLICK NEXT

 COVID-19 Vaccination ▲

Gender (at birth)

Male

Female

Prefer not to specify

Are you pregnant, plan to become pregnant or are you breastfeeding?

Yes

No

Are you a Female between 18 and 49 years of age?

Yes

No

Are you a male between 12 and 29 years of age?

Yes

No

What is your racial background?

Asian

Black/African American

White

Native American/Alaskan Native

Native Hawaiian/Other Pacific Islander

Other

Unknown

Not specified

What is your ethnic background?

Hispanic/Latino

Non-Hispanic/Latino

Not specified

Do you have a history of heparin-induced thrombocytopenia (HIT) or history of or a risk factor for a blood clotting disorder?

Yes

No

Do you have a history of myocarditis or pericarditi?

Yes

No

Do you have a history of multisystem inflammatory syndrome; either MIS-C (children) or MIS-A (adults)?

Yes

No

Do you have a bleeding disorder or are you on a blood thinner?

Yes

No

Are you immunocompromised or are you on medicine that affects your immune system or have a history of Guillain-Barre or Bell's Palsy?

Yes

No

Do you have a history of using dermal filler?

Yes

No

Have you ever had a severe allergic reaction to another vaccine (other than a COVID-19 vaccine) or an injectable medication? This would include food, pets, venom, environmental, or oral medication allergic?

Yes

No

Have you ever had an allergic reaction to a component of a COVID-19 vaccine including Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steriods?

Yes

No

Have you ever had an allergic reaction to a component of a COVID-19 vaccine including Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures?

Yes

No



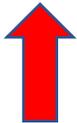
TYPE IN YOUR ZIP CODE AND HIT SEARCH(YOUR ZIP CODE SHOULD AUTO POPULATE)

 COVID-19 Vaccination ^

Select a vaccination location. If you are not at the zip code shown, change the zip code to show vaccination locations nearby.

Select ZIP Code

ZIP code 



 Pfizer EUA fact sheet ^

 Prior to vaccinating, please review the Pfizer EUA Patient Fact Sheet below.

- Pfizer Vaccine Patient Fact Sheet
- Hoja informativa para el paciente sobre la vacuna Pfizer
- Pediatric Pfizer Vaccine Patient Fact Sheet

 FAQ's ^

 Click below to find the CDC's answers to commonly asked questions about COVID-19 vaccination.

- CDC Frequently Asked Questions about COVID-19 Vaccination

 V-Safe Information Sheet ^

v-safe is the after vaccination health checker!

- CDC V-Safe Information Sheet

ALL LOCATIONS OFFERING A VACCINE CLINIC THROUGH YOUR EMPLOYER WILL APPEAR HERE.
CLICK ON THE SELECT OPTION NEXT TO THE LOCATION ADDRESS THAT APPEARS.

COVID-19 Vaccination ^

Select a vaccination location. If you are not at the zip code shown, change the zip code to show vaccination locations nearby.

Select Vaccination Location

ZIP code 94588

[Change](#)

Workday
6160 Stoneridge Mall Rd
Pleasanton, CA 94588

 [Select](#)

[Cancel](#)

Pfizer EUA fact sheet ^



Prior to vaccinating, please review the Pfizer EUA Patient Fact Sheet below.

- [Pfizer Vaccine Patient Fact Sheet](#)
- [Hoja informativa para el paciente sobre la vacuna Pfizer](#)
- [Pediatric Pfizer Vaccine Patient Fact Sheet](#)

FAQ's ^



Click below to find the CDC's answers to commonly asked questions about COVID-19 vaccination.

- [CDC Frequently Asked Questions about COVID-19 Vaccination](#)

V-Safe Information Sheet ^

v-safe is the after vaccination health checker!

- [CDC V-Safe Information Sheet](#)

CLICK "SELECT" NEXT TO THE DAY YOU WOULD LIKE TO SCHEDULE AN APPOINTMENT FOR.

The screenshot displays a user interface for scheduling a COVID-19 vaccination. It is divided into three main sections:

- COVID-19 Vaccination:** This panel allows users to select an appointment date. It shows the location as 6160 Stoneridge Mall Rd, Pleasanton, CA 94588. Under the "Select Date" section, three dates are listed: Monday, Nov 29; Tuesday, Nov 30; and Wednesday, Dec 1. Each date has a "Select" button next to it, with a red arrow pointing to the button. A "Change" button is located next to the location information, and a "Cancel" button is at the bottom.
- Pfizer EUA fact sheet:** This panel provides information about the Pfizer vaccine. It includes a doctor icon and text stating, "Prior to vaccinating, please review the Pfizer EUA Patient Fact Sheet below." Below this, there is a list of three links: "Pfizer Vaccine Patient Fact Sheet", "Hoja informativa para el paciente sobre la vacuna Pfizer", and "Pediatric Pfizer Vaccine Patient Fact Sheet".
- FAQ's:** This panel offers frequently asked questions about COVID-19 vaccination. It features the CDC logo and text: "Click below to find the CDC's answers to commonly asked questions about COVID-19 vaccination." A link is provided: "CDC Frequently Asked Questions about COVID-19 Vaccination".
- V-Safe Information Sheet:** This panel introduces the V-Safe health checker. It includes the text "v-safe is the after vaccination health checker!" and a link: "CDC V-Safe Information Sheet".

CLICK THE DROPDOWN ARROW TO SELECT A TIME

COVID-19 Vaccination

Select a time to be vaccinated on the selected date.

Appointment

Workday
6160 Stoneridge Mall Rd
Pleasanton, CA 94588

Select Time

Monday, Nov 29

Select time

Change

Cancel

Pfizer EUA fact sheet

Prior to vaccinating, please review the Pfizer EUA Patient Fact Sheet below.

- Pfizer Vaccine Patient Fact Sheet
- Hoja informativa para el paciente sobre la vacuna Pfizer
- Pediatric Pfizer Vaccine Patient Fact Sheet

FAQ's

Click below to find the CDC's answers to commonly asked questions about COVID-19 vaccination.

- CDC Frequently Asked Questions about COVID-19 Vaccination

V-Safe Information Sheet

v-safe is the after vaccination health checker!

- CDC V-Safe Information Sheet

ONCE TIME HAS BEEN SELECTED, PLEASE CLICK **CONFIRM**.

COVID-19 Vaccination

Select "Confirm" to book your appointment.

 [Confirm](#)

Appointment

Workday
6160 Stoneridge Mall Rd
Pleasanton, CA 94588 [Change](#)

Monday, Nov 29
11:00AM-12:00PM [Change](#)

Please confirm your e-mail address.

E-mail:
nramos@impacthealth.com [Change](#)

[Cancel](#)

Pfizer EUA fact sheet

 Prior to vaccinating, please review the Pfizer EUA Patient Fact Sheet below.

- [Pfizer Vaccine Patient Fact Sheet](#)
- [Hoja informativa para el paciente sobre la vacuna Pfizer](#)
- [Pediatric Pfizer Vaccine Patient Fact Sheet](#)

FAQ's

 Click below to find the CDC's answers to commonly asked questions about COVID-19 vaccination.

- [CDC Frequently Asked Questions about COVID-19 Vaccination](#)

V-Safe Information Sheet

v-safe is the after vaccination health checker!

- [CDC V-Safe Information Sheet](#)

PLEASE CLICK [EMAIL OR PRINT](#) TO OBTAIN THE VOUCHER ID, AS YOU WILL NEED THIS VOUCHER ID NUMBER TO CHECK INTO YOUR APPOINTMENT UPON ARRIVAL.
[DO NOT CLICK CANCEL!](#)

COVID-19 Vaccination

Your First Dose Vaccination is Scheduled

Location

Workday
6160 Stoneridge Mall Rd
Pleasanton, CA 94588

Date

Monday, Nov 29

Time

11:00AM-12:00PM

Voucher ID: 30577451

PRINT and BRING this voucher with you to your vaccination appointment. If you cannot print your voucher, one will be printed at the location.

E-mail

Print

Cancel



Pfizer EUA fact sheet



Prior to vaccinating, please review the Pfizer EUA Patient Fact Sheet below.

- Pfizer Vaccine Patient Fact Sheet
- Hoja informativa para el paciente sobre la vacuna Pfizer
- Pediatric Pfizer Vaccine Patient Fact Sheet

FAQ's



Click below to find the CDC's answers to commonly asked questions about COVID-19 vaccination.

- CDC Frequently Asked Questions about COVID-19 Vaccination

V-Safe Information Sheet

v-safe is the after vaccination health checker!

- CDC V-Safe Information Sheet

IF YOU CLICK EMAIL, VERIFY EMAIL ADDRESS AND CLICK “SEND”

The screenshot displays a web interface with three main content areas. On the left, a 'COVID-19 Vaccination' section prompts the user to confirm their email address. The email field contains 'nramos@impacthealth.' and features 'Cancel' and 'Send' buttons. A large red arrow points to the 'Send' button. The middle section, 'Pfizer EUA fact sheet', includes a doctor icon and a list of three links: 'Pfizer Vaccine Patient Fact Sheet', 'Hoja informativa para el paciente sobre la vacuna Pfizer', and 'Pediatric Pfizer Vaccine Patient Fact Sheet'. The right section, 'FAQ's', features the CDC logo and a list of links, including 'CDC Frequently Asked Questions about COVID-19 Vaccination'. Below the FAQ's is a 'V-Safe Information Sheet' section with the text 'v-safe is the after vaccination health checker!' and a link to the 'CDC V-Safe Information Sheet'. The bottom of the page features the Impact Health logo.

COVID-19 Vaccination

Please confirm your email address.

Email

[Cancel](#) [Send](#)

Pfizer EUA fact sheet

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- [Hoja informativa para el paciente sobre la vacuna Pfizer](#)
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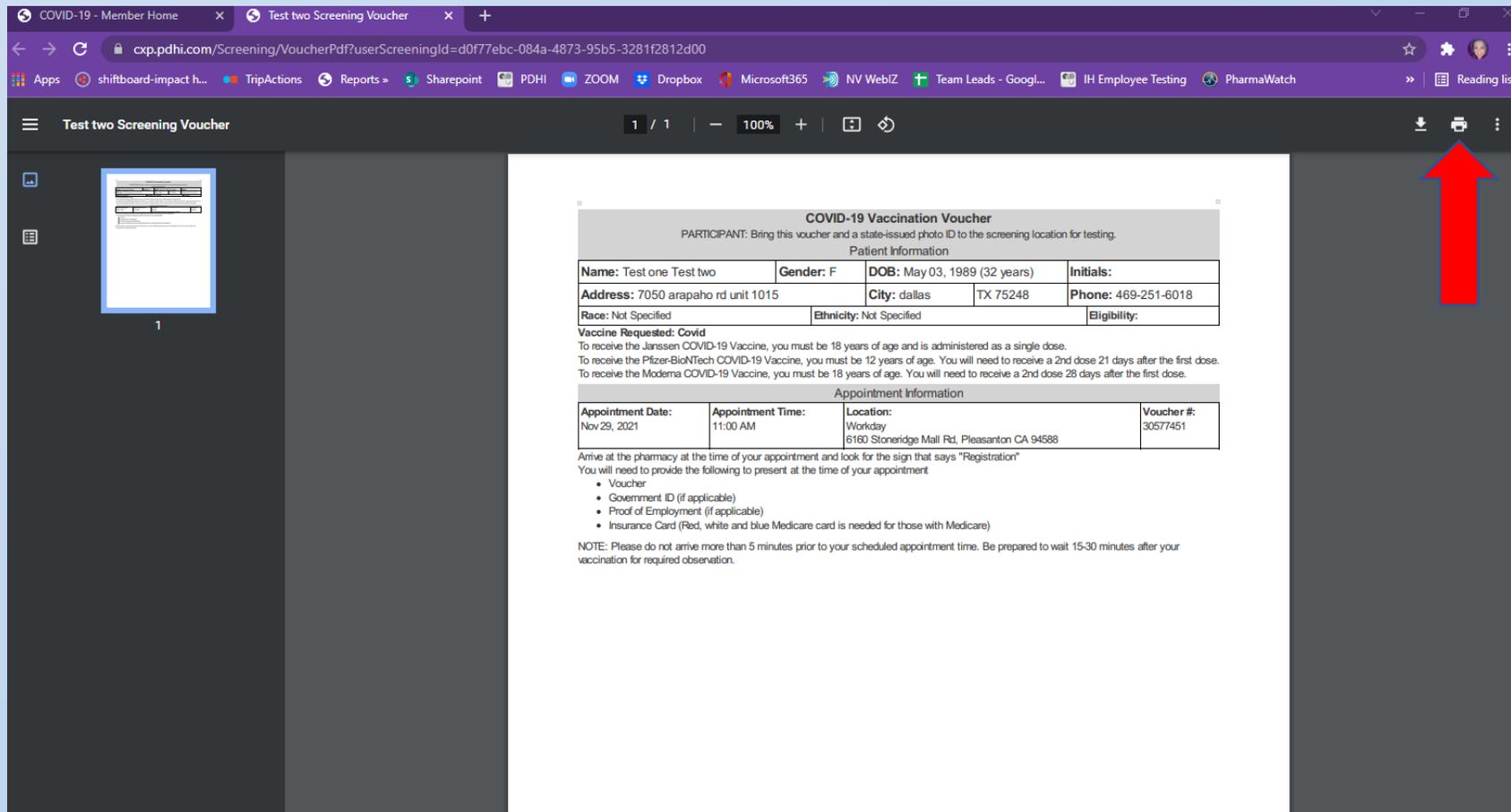
V-Safe Information Sheet

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- [CDC V-Safe Information Sheet](#)



IF YOU CLICK PRINT, THE DOCUMENT WILL APPEAR OPEN IN ANOTHER TAB AND YOU WILL PRINT FROM THAT TAB.



The screenshot shows a web browser window with two tabs: "COVID-19 - Member Home" and "Test two Screening Voucher". The address bar shows the URL: cxp.pdhi.com/Screening/VoucherPdf?userScreeningId=d0f77ebc-084a-4873-95b5-3281f2812d00. The browser toolbar includes a print icon, which is highlighted by a red arrow. The document content is as follows:

COVID-19 Vaccination Voucher
PARTICIPANT: Bring this voucher and a state-issued photo ID to the screening location for testing.

Patient Information

Name: Test one Test two	Gender: F	DOB: May 03, 1989 (32 years)	Initials:
Address: 7050 arapaho rd unit 1015	City: dallas	TX 75248	Phone: 469-251-6018
Race: Not Specified	Ethnicity: Not Specified	Eligibility:	

Vaccine Requested: Covid
To receive the Janssen COVID-19 Vaccine, you must be 18 years of age and is administered as a single dose.
To receive the Pfizer-BioNTech COVID-19 Vaccine, you must be 12 years of age. You will need to receive a 2nd dose 21 days after the first dose.
To receive the Moderna COVID-19 Vaccine, you must be 18 years of age. You will need to receive a 2nd dose 28 days after the first dose.

Appointment Information

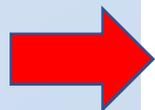
Appointment Date: Nov 29, 2021	Appointment Time: 11:00 AM	Location: Workday 6160 Stoneridge Mall Rd, Pleasanton CA 94588	Voucher #: 30577451
---------------------------------------	-----------------------------------	--	----------------------------

Arrive at the pharmacy at the time of your appointment and look for the sign that says "Registration"
You will need to provide the following to present at the time of your appointment

- Voucher
- Government ID (if applicable)
- Proof of Employment (if applicable)
- Insurance Card (Red, white and blue Medicare card is needed for those with Medicare)

NOTE: Please do not arrive more than 5 minutes prior to your scheduled appointment time. Be prepared to wait 15-30 minutes after your vaccination for required observation.

REGISTRATION IS NOW COMPLETE! YOU CAN LOG BACK INTO THE PORTAL, IF NECESSARY, WITH THE USERNAME AND PASSWORD YOU CREATED IN THE BEGINNING OF THE REGISTRATION PROCESS TO CHANGE OR CANCEL THIS APPOINTMENT IF NECESSARY.



COVID-19 Vaccination ^

Your First Dose Vaccination is Scheduled

Location

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Pleasanton, CA 94588

Date

Monday, Nov 29

Time

11:00AM-12:00PM

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E-mail

Print

Cancel

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