



IM Injection Acknowledgement

I have received, reviewed, and understand Triad Care, Inc.'s Intramuscular (IM) Injection Protocol. I understand that, if required, I will not administer any injection without a supervising clinician present.

I understand that any damaged, ruined, or wasted vaccine doses are to be returned to Triad Care, Inc. and should not be discarded by providers.

I have read and understand Triad Care, Inc.'s infection control policy for vaccination events.

I understand if I have any questions regarding protocols or expectations, I should contact my immediate supervisor before I take additional action.

Name: _____

Signature: _____

Date: _____