

ATTESTATION: THIRD DOSE OF COVID-19 VACCINE FOR IMMUNOCOMPROMISED

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| NAME: LAST | FIRST | MIDDLE INITIAL |
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| DATE OF BIRTH | GENDER | PHONE NUMBER |
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| ADDRESS | CITY | STATE | ZIP |
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_____ INITIAL

I am a moderately to severely immunocompromised individual (who) either has and/or is receiving treatment for one of the following:

- Active or recent treatment for solid tumor and hematologic malignancies
- Other hematologic disorder which can cause an immunocompromised state
- Receipt of solid-organ or recent hematopoietic stem cell transplants
- Moderate or severe primary immunodeficiency (e.g., DiGeorge, Wiskott-Aldrich syndromes)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids (i.e., ≥ 20 mg prednisone or equivalent per day), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor-necrosis (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory.

_____ INITIAL

It has been at least 28 days since my second dose of the COVID-19 vaccine.

_____ INITIAL

I am at least 12 years old to receive the third dose of the Pfizer COVID-19 vaccine or at least 18 years old to receive the third dose of the Moderna COVID-19 vaccine.

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| SIGNATURE | DATE |
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| NAME AND RELATIONSHIP TO PATIENT (IF MINOR OR GUARDIANSHIP) |
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