

# Self-Attestation Statement for COVID-19 Vaccine Recipient

## Please indicate your eligibility to receive an additional dose of COVID-19 vaccine:

- I am an individual whose immune system is moderately or severely compromised due to a medical condition or the effects of a medication or treatment, as identified by the Centers for Disease Control and Prevention (CDC).\* I request a third dose of an mRNA COVID-19 vaccine.

### \*Please check the appropriate box below:

- Been receiving active cancer treatment for tumors or cancers of the blood
- Received an organ transplant and are taking medicine to suppress the immune system
- Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system
- Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced or untreated HIV infection
- Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response

Date of second COVID-19 mRNA dose: \_\_\_\_\_

*Note: Third dose should be administered at least 28 days after second dose.*

Vaccine product received: \_\_\_\_\_

Print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

