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:

- ☐ Active treatment for solid tumor and hematologic malignancies
- ☐ Receipt of solid-organ transplant and taking immunosuppressive therapy
- ☐ Receipt of CAR T-cell or hematopoietic stem cell transplant (within 2 years of transplantation or taking immunosuppression therapy)
- ☐ Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- ☐ Advanced or untreated HIV infection
- ☐ Active treatment with high-dose corticosteroids (i.e., ≥ 20 mg prednisone or equivalent per day)
- ☐ Active treatment with alkylating agents
- ☐ Active treatment with antimetabolites
- ☐ Active treatment with transplant-related immunosuppressive drugs
- ☐ Active treatment with cancer chemotherapeutic agents classified as severely immunosuppressive
- ☐ Active treatment with tumor-necrosis (TNF) blockers
- ☐ Active treatment with other biologic agents that are immunosuppressive or immunomodulatory

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: _____