**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**