**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.**

\*<https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#considerations-additional-vaccine-dose>

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