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