

Certification of Eligibility for Pfizer/Moderna Booster Vaccine

Name:		Date:	
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I understand that the COVID-19 vaccine is subject to strict prioritization in accordance with Centers for Disease Control and New York State Department of Health directives. With that understanding, and with the understanding that I will have to supply proof of my eligibility, I hereby certify under penalty of law that I belong to one of the groups below making me eligible for a Pfizer booster:

- I am age 65 or older and I reside in New York State.
- I am a resident of a long term care facility
- I am over 18 with increased risk for exposure to COVID-19 based on an institutional setting or employment (ie. medical worker, teacher of students under age 12, first responder)
- I am over 18, reside in New York State and have one of the following conditions to qualify for the vaccine:

<input type="checkbox"/> Cancer (current or in remission, including 9/11-related cancers)	<input type="checkbox"/> Chronic kidney disease
<input type="checkbox"/> Pulmonary Disease, including but not limited to, COPD (chronic obstructive pulmonary disease), asthma (moderate-to-severe), pulmonary fibrosis, cystic fibrosis, and 9/11 related pulmonary diseases	<input type="checkbox"/> Immunocompromised state (weakened immune system) including but not limited to solid organ transplant or from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, use of other immune weakening medicines, or other causes
<input type="checkbox"/> Heart conditions, including but not limited to heart failure, coronary artery disease, cardiomyopathies, or hypertension (high blood pressure)	<input type="checkbox"/> Intellectual and Developmental Disabilities including Down Syndrome
<input type="checkbox"/> Severe Obesity (BMI 40 kg/m ²), Obesity (body mass index [BMI] of 30 kg/m ² or higher but < 40 kg/m ²)	<input type="checkbox"/> Cerebrovascular disease (affects blood vessels and blood supply to the brain)
<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Sickle cell disease or Thalassemia
<input type="checkbox"/> Type 1 or 2 diabetes mellitus	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Neurologic conditions including but not limited to Alzheimer's Disease or dementia	

Signature: _____