To Whom It May Concern:

I request that [Name] be eligible for a Covid-19 vaccine due to a clinically diagnosed condition that puts them at increased risk of severe illness from the virus that causes Covid-19.3

I certify that this person has a clinical diagnosis of (check all that apply):

☐ Cancer
☐ Chronic kidney disease
☐ Chronic obstructive pulmonary disease or COPD
☐ Down Syndrome
☐ Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
☐ Immunocompromised state (weakened immune system) from solid organ transplant
☐ Severe Obesity (BMI ≥ 40 kg/m2)
☐ Obesity (body mass index [BMI] of 30 kg/m2 or higher but < 40 kg/m2)
☐ Pregnancy
☐ Sickle cell disease
☐ Smoking
☐ Type 2 diabetes mellitus

Therefore, I certify that this individual is eligible for the Covid-19 vaccine.

Sincerely,

_________________________ _________________________
Healthcare Professional Name Organization/Office

_________________________ _________________________
Healthcare Professional Signature Date