Dear Tule River Tribal Community,

The Tule River Indian Health Center, Inc (TRIHCI) has a limited number of Covid-19 vaccines available to the community. Covid-19 vaccines were developed using a transparent, rigorous process and recommended by a panel of experts. All safety protocols were followed in their development.

As of today, March 9, 2021, Covid-19 vaccines are available for the following groups:

1. **Healthcare workers**, which includes all TRIHCI Staff.
2. **Tribal Elders**, which includes Elders of the Tule River Tribe of California, Native American Elders living in Tulare County, and any Elder (+55 years old) in a Tribal Household.
3. **Essential Workers**, which includes employees of all organizations that the Tule River Tribal Council declared as essential.
4. **Frontline Workers on the Reservation**: Any resident of the Tule River Indian Reservation who works as a frontline healthcare worker, or in a Fire Department, Police Department, or in Emergency Medical Services (EMS). (Note, verification of employment and residency will be requested.)
5. **Adults, 18-54 years old, with high-risk medical conditions**: Anyone age 18-54 with a medical condition, listed below, which makes them at increased risk of severe illness from Covid-19.

If you are in one of these groups and want to request a vaccine, please call **559-853-6123** or **559-784-2316** to add your name to our scheduling list.

The goal of this phased rollout is to protect those at highest risk of Covid-19 first. The Tule River Public Health Authority continues to follow the intentions of the prioritized groups for Covid-19 vaccines according to the guidelines proposed by the US Federal government.¹

Sincerely,

Eric Coles
Dr. Eric Coles
Tribal Public Health Officer
Tule River Public Health Authority

¹ [https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm](https://www.cdc.gov/mmwr/volumes/69/wr/mm695152e2.htm)
List of High-Risk Medical Conditions

We will verify that you have a condition listed below. If you are a TRIHCI patient, we will confirm with your medical record. If you are NOT a TRIHCI patient, please have your healthcare provider complete the letter on the next page and bring it with you to your vaccine appointment.

The CDC lists\(^2\) the underlying medical conditions that make people at increased risk for severe illness, which is defined as hospitalization, admission to the ICU, intubation or mechanical ventilation, or death. The PHA and TRIHCI will offer vaccines to people with a clinical diagnosis of the following conditions:

- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- 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/m\(^2\))
- Obesity (body mass index [BMI] of 30 kg/m\(^2\) or higher but < 40 kg/m\(^2\))
- Pregnancy
- Sickle cell disease
- Smoking
- Type 2 diabetes mellitus

To Whom It May Concern:

I request that [NAME OF INDIVIDUAL] 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