Pfizer COVID-19 Vaccine Booster Dose
Self-Attestation of Eligibility

I ____

(print name)

Attest that I am eligible for a booster dose of Pfizer mRNA COVID-19 vaccine based on the criteria below.

- I received a second dose of Pfizer COVID-19 vaccine at least 6 months ago, AND
  - I am age 65 years or older, OR
  - I live in a long-term care setting, OR
  - I am age 18-64 and am at increased risk for COVID-19 exposure and transmission becauseof my work or institutional setting, OR
  - I am age 18-64 and I have one of the following underlying medical conditions:
    - Cancer
    - Chronic kidney disease
    - Chronic lung disease, including COPD (chronic obstructive pulmonary disease), asthma(moderate-to-severe), interstitial lung disease, cystic fibrosis, and pulmonary hypertension
    - Dementia or other neurological conditions
    - Diabetes (type 1 or type 2)
    - Down syndrome
    - Heart conditions (such as heart failure, coronary artery disease, cardiomyopathies orhypertension)
    - HIV infection
    - Immunocompromised state (weakened immune system)
    - Liver disease
    - Overweight or obesity (body mass index (BMI) over 25 kg/m2
    - Pregnant and recently pregnant (for at least 42 days following end of pregnancy)
    - Sickle cell disease or thalassemia
    - Smoker, current or former
    - Solid organ or blood stem cell transplant
    - Stroke or cerebrovascular disease, which affects blood flow to the brain
    - Substance use disorder

I furthermore attest that I have previously received a two-dose series of Pfizer mRNA COVID-19 vaccine.

Signature: ________________________________**Date:** ______________