**Self-Attestation Form for COVID-19 Vaccination: Pfizer Booster Doses**

CDC recommends that people can receive a booster shot of Pfizer-BioNTech to help maintain immunity that may decrease over time if:

* You are **fully vaccinated** with two shots of Pfizer, AND
* It has been at least **6 months** since your last Pfizer shot

AND you fit into one of the following categories:

* 65+ years of age, OR
* Resident of a long-term care facility, OR
* 18+ years of age with underlying medical conditions, OR
* 18+ years of age in certain occupations that increase your risk of exposure or transmission

Date of second dose of Pfizer shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark one of the following and sign at the bottom to acknowledge your need for a booster dose.**

\_\_\_\_ I am 65 years of age or older

\_\_\_\_ I am a resident of a long term care facility

\_\_\_\_ I am 18-64 years of age with one of following underlying medical conditions:

 -chronic kidney disease - overweight or obese

 -chronic lung disease (asthma, COPD) - pregnancy

 -dementia or other neurological condition - sickle cell disease or thalassemia

 -diabetes - smoking (current or former)

 -Down’s syndrome - stroke

 -heart conditions (heart failure, coronary artery disease, cardiomyopathies)

 -hypertension - substance abuse disorder

 - liver disease

-other medical conditions determined by your medical provider

\_\_\_\_ I am 18-64 years of age and work in one of the following occupations or settings:

 -first responder (healthcare, firefighters, police, congregate care staff)

 -education staff (teachers, support staff, daycare workers)

 -grocery store worker - manufacturing worker

 -food and agriculture worker - corrections worker

People should talk to their healthcare provider about their medical condition, and whether getting an additional dose is appropriate for them.

Printed Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_