Certification of Membership in Priority Vaccination Group

Name:		Date:	

I understand that vaccine supply is currently limited and, therefore, 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 below priority groups eligible for vaccination:

- ☐ I am age 65 or older and I reside in New York State.
- ☐ I am currently employed by a New York employer, or am otherwise eligible in New York based on work, paid or unpaid, in New York, in one of the following categories, and am either required to have in-person contact with members of the public or with coworkers, or I am unable to work remotely. For a full list, please visit https://forms.ny.gov/s3/vaccine
- ☐ I am over 18, reside in New York State and have one of the following conditions to qualify for the vaccine:

• Cancer (current or in remission, including 9/11-related cancers)	• Chronic kidney disease
• 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	• 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
• Heart conditions, including but not limited to heart failure, coronary artery disease, cardiomyopathies, or hypertension (high blood pressure)	• Intellectual and Developmental Disabilities including Down Syndrome
• Severe Obesity (BMI 40 kg/m2), Obesity (body mass index [BMI] of 30 kg/m2 or higher but < 40 kg/m2)	• Cerebrovascular disease (affects blood vessels and blood supply to the brain)
• Pregnancy	• Sickle cell disease or Thalassemia
• Type 1 or 2 diabetes mellitus	• Liver disease
• Neurologic conditions including but not limited to Alzheimer's Disease or dementia	

Signature:_____