Verification of COVID-19 Medical Risk Factors

PATIENT INFORMATION:

Patient's Name:_____ Patient's Phone #:_____

PROVIDER INFORMATION:

Provider's Name:_____ Provider's Phone #:_____

Provider's Address (stamp is acceptable):_____

The patient identified above has, or has been under treatment for, one or more of the following CDC recognized risk factors and/or diagnoses putting them at higher risk for COVID-19.

- Chronic lung disease, or moderate to severe Asthma
- Serious heart conditions (such as cardiovascular disease or heart failure)
- Hypertension
- Immune system compromise (to include HIV and cancer treatment)
- Severe obesity (BMI > 40)
- Diabetes, kidney disease, liver disease or cerebrovascular disease
- Other - CDC "high risk" and "special populations" https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/index.html

The patient meets the CDC guidelines for "high risk" or "special population" as of the date of the attached self-certification.

Provider's Signature _____ Date: _____

Provider's Printed Name _____