Erie County Department of Health

Public Health
Prevent. Promote. Protect.

COVID-19 Vaccine – Additional Dose Attestation

I hereby certify under penalty of law that I myself am, or the person for whom I am legally authorized to make health care decisions, fall into one of the following categories:

- 5 years of age or older and in the process of completing my initial Pfizer COVID-19 vaccine series; OR
- 12 years of age or older, immunocompromised (e.g., moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments) and received a completed COVID-19 vaccine series at least 28 days ago; OR
- 18 years of age or older and either: in the process of completing my initial Janssen (J&J) or Moderna COVID-19 vaccine series, or received a WHO-authorized COVID-19 vaccine and require a dose of Pfizer or Moderna COVID-19 vaccine to complete my vaccine series, or received a completed WHO authorized vaccine series at least 5 months ago and require a booster dose; OR
- 12 years of age or older and either received the Pfizer vaccine at least 5 months ago or received an initial booster dose at least 4 months ago and immunocompromised (e.g., moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments); OR
- 18 years of age or older and received either the Moderna vaccine series at least 5 months ago, the Janssen/J&J vaccine at least 2 months ago, or the Janssen/J&J vaccine as both a primary series and an initial booster dose at least 4 months ago; OR
- 50 years or older and received an initial booster dose at least 4 months ago.

and therefore, authorized by an Emergency Use Authorization or Emergency Use Instructions to receive this vaccine.

Note: Per the New York State Department of Health (NYSDOH), the Emergency Use Authorization amendment for additional doses is not intended for persons with chronic conditions such as diabetes or heart disease, for which there might be mild associated immunosuppression, nor for residents of long-term care facilities who do not otherwise meet the moderate to severe immunocompromised criteria. The New York State Department of Health lists qualifying comorbidities and conditions at https://www.ny.gov/sites/ny.gov/files/atoms/files/ComordbititiesCOVID19.pdf

Patient Information

Name (print): _____ Date of Birth: _____/_____/_____

Phone Number: (_____)_____-_____ State: _____ ZIP Code: _____

Patient Signature: _____ Date: _____/_____/_____

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____ Date: _____/_____/_____

Updated 04/07/2022