COVID-19 Determination of Extreme Vulnerability

Physician Name:____
Last/Surname First Middle

Physician License Number: _______________________ **Physician Telephone Number:** ____________________

Physician Practice Address: ____

Physician Email Address:__________________________________

Patient Name: ____
Last/Surname First Middle

Patient Date of Birth: ________________________________

Patient Address: ____

City: _________________________ **State:** ______________ **ZIP Code:** _______________________

Patient Telephone Number: ____

CERTIFICATION OF PATIENT'S EXTREME VULNERABILITY TO COVID-19

I hereby certify that I have a physician-patient relationship with the patient named above and that I have determined that the patient is extremely vulnerable to COVID-19 for the purposes of receiving a COVID-19 vaccination in the state of Florida.

I attest that I am the physician listed above and the statements in this determination are true and complete.

Physician's Signature: ____ **Date:** ____________
MM/DD/YYYY