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