**GENESEE AND ORLEANS COUNTY HEALTH DEPARTMENTS**

Genesee County Health Department
3837 West Main Street Road
Batavia, NY 14020
Phone: (585) 344-2580 ext. 5555
Fax: (585) 344-4713

Paul A. Pettit, MSL
Public Health Director

Orleans County Health Department
14016 Rt. 31 West, Suite 101
Albion, NY 14411
Phone: (585) 589-3278
Fax: (585) 589-2873

Brenden A. Bedard, MPH
Deputy Director

## Eligible Prioritization Groups

Your Printed Name: _____ Today's Date: _____

**I attest that I belong to the following prioritization group(s)**

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 18 or older, reside in New York State and have one of the following conditions to qualify for the vaccine:

For a full list, please visit https://forms.ny.gov/s3/vaccine**:** *please circle number(s) as appropriate:*

1. Hospital Staff
2. Long-term Care Facility Health Provider
3. Long-term Care Facility Resident
4. Other Healthcare Provider
5. Emergency Medical Services (EMS)
6. Medical Examiner, Coroner, Mortician
7. Resident in Congregate Setting
8. Public Safety Including Police, Fire, Corrections, etc.
9. Healthcare Provider/Walk-in Center Staff
10. 75 or older
11. 65-74
12. Under 65 with underlying health conditions at high risk (**TURN PAGE OVER**)
13. Frontline workers in food/agriculture, UPS, manufacturing, grocery, public transit, education (teacher, support staff, daycare)
14. Other essential staff (transportation and logistics, food service, housing construction, finance, IT, communications, energy, law, public safety, and public health
15. Currently Pregnant

**Signature:** _____

## Certification of Membership in Priority Vaccination Group #12 ONLY

Only fill out this side if you selected #12 on the front

| Name: | | Date: | |
|---|---|---|---|

| | |
|---|---|
| ☐ 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:** _____