Certification of Membership in Priority Vaccination Group

Wyoming County Health Department, 5362 Mungers Mill Road, Silver Springs, NY

Public Health
Prevent. Promote. Protect.

Name:	

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 age 65 or older and I reside in New York State.
- ☐ I am a resident of NY and currently perform work in one of the eligible categories, either paid or unpaid, or I am a non-resident but perform such work in NY. For a full list, please visit https://forms.ny.gov/s3/vaccine
- ☐ I am over 18, reside in New York State and have one of the following conditions to qualify for the vaccine:

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:_____ Date:_____ v1 02/16/2021