

## PERSONAL AND CONTACT INFORMATION

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Please fill out ALL the information below

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Email:** \_\_\_\_\_

I do not have an email/ I do not wish to disclose this information

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_ **County:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_

### Communication Preference:

- Email                       Both  
 Text                         None

### Race:

- American Indian or Alaska Native  
 Asian  
 Black or African American  
 White  
 Other

### Ethnicity:

- Hispanic or Latino  
 Not Hispanic or Latino

### Gender:

- Male  
 Female  
 Unknown

### Are you a member of a state or federal recognized tribal nation?

- Yes  
 No

If yes, what is the name of the community? \_\_\_\_\_

## RISK LEVEL INFORMATION

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Review the below list of conditions known to increase risk of severe illness to COVID-19:

- Asthma
- Cancer
- Cerebrovascular Disease
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease
- Cystic Fibrosis
- Hypertension or High Blood Pressure
- Type 1 Diabetes Mellitus
- Type 2 Diabetes
- Immunocompromised from solid organ transplant
- Immunocompromised state (weakened immune system)
- Liver Disease
- Neurologic conditions, such as Dementia
- Obesity
- Overweight (BMI > 25 kg/m<sup>2</sup>, but < 30 kg/m<sup>2</sup>)
- Pregnancy
- Pulmonary Fibrosis (having damaged or scarred lung tissues)
- Sickle Cell Disease
- Smoker
- Thalassemia (a type of blood disorder)

### How many conditions known to increase risk of severe illness from COVID-19 do you have?

- None  
 1  
 2 or more

**Do you identify as any of the following?**

- High Risk (Phase 1a) Healthcare Worker
- Patient-facing Healthcare Worker
- Frontline Essential Worker
- Other Essential Worker (non-frontline)
- Resident of Long Term Care Facility
- Resident of Congregate/Group Setting
- Student
- None of the above

Insurance Information (if applicable):

Provider \_\_\_\_\_

Subscriber ID# \_\_\_\_\_

*The CDC defines frontline essential workers as first responders (e.g., firefighters and police officers), corrections officers, food and agricultural workers, U.S. Postal Service workers, manufacturing workers, grocery store workers, public transit workers, and those who work in the education sector (teachers and support staff members) as well as child care workers. Patient facing direct health care workers includes any paid or unpaid health care workers with direct patient contact.*

**What is the name of the organization you work or reside in?** \_\_\_\_\_

**Please select your Industry (Please Select Only One):**

**Frontline Essential Workers**

- Congregant/Community Work
- Corrections Workers
- Education (Teachers, Support Staff, Child Care)
- First Responders
- Food and Agriculture
- Grocery Store
- Health Care Provider
- Manufacturing
- Public Transit
- US Postal Service

**Other Essential Workers (Not Frontline)**

- Commercial Facilities (Retail, Business, Entertainment, Lodging)
- Energy
- Finance
- Food service
- Governmental services
- Health Care Provider
- Hygiene Products and Services
- Industries involving Chemicals or Hazardous Materials
- IT & Communication
- Legal
- Media
- Public Health
- Public Safety (Engineers)
- Public Works and Infrastructure Support Services
- Shelter and Housing Services
- Transportation and Logistics
- Water and Wastewater

**Other Industries**

- College/University
- K-12 School
- Other

**CONSENT**

- I certify that I am: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an "applicable Provider"), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine. I understand that the health data shared within this questionnaire will be used to determine my eligibility for receiving the COVID-19 vaccination and further determine timing of when the vaccine will be made available to me.

\_\_\_\_\_  
Signature of Recipient