

(Print the name and address of the doctor recommending the additional dose)

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Date.....

RECOMMENDATION FOR ADDITIONAL DOSE OF COVID -19 VACCINE BY ATTENDING CLINICIAN

This serves to certify that the patient, with
D.O.B..... ; is eligible for the additional of COVID-19.

Reason for eligibility is that the patient fall in the group encircled below.

Group	Details
Active cancer	<ul style="list-style-type: none"> • Active immunosuppressive treatment for solid tumour or haematological malignancy (including leukaemia, lymphoma, and myeloma), or within 12 months of ending such treatment
Transplant recipients	<ul style="list-style-type: none"> • Receipt of solid organ transplant and taking immunosuppressive therapy • Receipt of stem cell transplant (within 2 years of transplantation, or taking immunosuppressive therapy)
Immunodeficiency	<ul style="list-style-type: none"> • Severe primary immunodeficiency • Chronic dialysis
HIV	<ul style="list-style-type: none"> • HIV with a current CD4 cell count of <200 cells/μl, evidence of an opportunistic infection, not on HIV treatment, and/or with a detectable viral load (i.e. advanced HIV disease)
Immunosuppressives	<ul style="list-style-type: none"> • Active treatment causing significant immunosuppression, including high-dose corticosteroids, alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents, tumour-necrosis factor (TNF) blockers, or other highly immunosuppressive drugs • Immunosuppressive chemotherapy or radiotherapy within the past 6 months

Sincerely.

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Signature

Specialization

Medical Council of Jamaica Registration Number

Telephone number (Office, Mobile)