# 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:** _____

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## 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