

**Annexure 1(B): Certificate to identify individuals with co-morbidities that enhance the risk of mortality in COVID-19 disease for priority vaccination**

**(To be filled by a Registered Medical Practitioner)**

Name of beneficiary: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Mobile phone number: \_\_\_\_\_

Identification document: \_\_\_\_\_

I, Dr. \_\_\_\_\_, working as \_\_\_\_\_ have reviewed the above named individual and certify that he/she has the below mentioned conditions based on the records presented to me. A copy of the records on which this certificate is based is attached.

Presence of ANY ONE of the following criteria will prioritize the individual for vaccination

| SN  | Criterion   | Yes/No |
|-----|---|--------|
| 1.  | Heart Failure with hospital admission in past one year  |        |
| 2.  | Post Cardiac Transplant/Left Ventricular Assist Device (LVAD)   |        |
| 3.  | Significant Left ventricular systolic dysfunction (LVEF <40%)   |        |
| 4.  | Moderate or Severe Valvular Heart Disease   |        |
| 5.  | Congenital heart disease with severe PAH or Idiopathic PAH  |        |
| 6.  | Coronary Artery Disease with past CABG/PTCA/MI<br>AND Hypertension/Diabetes on treatment  |        |
| 7.  | Angina AND Hypertension/Diabetes on treatment   |        |
| 8.  | CT/MRI documented stroke AND Hypertension/Diabetes on treatment   |        |
| 9.  | Pulmonary artery hypertension AND Hypertension/Diabetes on treatment  |        |
| 10. | Diabetes (> 10 years OR with complications) AND Hypertension on treatment   |        |
| 11. | Kidney/ Liver/ Hematopoietic stem cell transplant: Recipient/On wait-list   |        |
| 12. | End Stage Kidney Disease on haemodialysis/ CAPD   |        |
| 13. | Current prolonged use of oral corticosteroids/ immunosuppressant medications  |        |
| 14. | Decompensated cirrhosis   |        |
| 15. | Severe respiratory disease with hospitalizations in last two years/FEV1 <50%  |        |
| 16. | Lymphoma/ Leukaemia/ Myeloma  |        |
| 17. | Diagnosis of any solid cancer on or after 1st July 2020 Or currently on any cancer therapy  |        |
| 18. | Sickle Cell Disease/ Bone marrow failure/ Aplastic Anemia/ Thalassemia Major  |        |
| 19. | Primary Immunodeficiency Diseases/ HIV infection  |        |
| 20. | Persons with disabilities due to Intellectual disabilities/ Muscular Dystrophy/ Acid attack with involvement of respiratory system/ Persons with disabilities having high support needs/ Multiple disabilities including deaf-blindness |        |

I am aware that providing false information is an offence.

Name of RMP: \_\_\_\_\_

Medical Council registration number of RMP: \_\_\_\_\_

Date of issuing the certificate: \_\_\_\_\_

Place of issue: \_\_\_\_\_.

(Signature of RMP)