NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs *for all*
Department of Health and Human Services

Bureau of Infectious Disease Control

MEDICAL VERIFICATION FORM FOR COVID-19 VACCINE

Patient Information

Name _____
(Last) (First) (M.I.)

Date of Birth _____/_____/_____

Primary Phone Number:_____ Other Phone Number:_____

Email: _____ ☐ Patient does not have access to email

Health Care Provider Information

☐ The above named patient has two or more medical conditions that I believe puts the patient at significantly increased risk for severe COVID-19 infection or death.

Healthcare Provider Name: _____ NPI or License #: _____

Provider Facility/Practice Name _____

Phone Number: _____City/Town_____ State_____

Fax to: (603) 271-3001 or Email to: covidvaccinescheduling@dhhs.nh.gov

List of Underlying Medical Conditions (adapted from CDC):
Phase 1b: Two or more conditions

- Cancer
- Chronic Kidney Disease
- COPD (Chronic Obstructive Pulmonary Disease)
- Down Syndrome
- Heart Conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index of 30 kg/m or higher but < 40 kg/m
- Severe Obesity (body > 40 kg/m)
- Pregnancy
- Sickle cell disease
- Other High Risk Pulmonary Disease
- Type 2 Diabetes Mellitus

Note: Flexibility is provided for a health care provider to vaccinate any patient whose primary care provider assesses a significant risk for severe illness due to any multiple co-occurring co-morbidities.

For questions about this form, call the COVID-19 Coordinating Office at 603-271-5980