## 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:	<del></del>
_	Mobile phone number:	<del></del>
_	Identification document:	<del></del>
_	Toolkine at the toolkine at th	
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	
	AND Hypertension/Diabetes on treatment	
7.	AnginaAND 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 yearsORwith 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 Orcurrently 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:  Madical Council registration number of RMP:		
Medical Council registration number of RMP:		
Date of issuing the certificate: (Signature of PMP)		
Place of issue: (Signature of RMP)		