**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 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)