Provider Clearance Form
COVID-19 VACCINE

QUESTIONS?
EMAIL: RHHDvax@vdh.virginia.gov
HOTLINE: (804) 205-3501

CERTIFICATION

I, Dr. _____, certify that I have an established doctor-patient relationship with _____. I have carefully reviewed their medical history, including their history of anaphylaxis to injected medical therapy. After review of the components of the Pfizer and Moderna vaccine, including polyethylene glycol and polysorbates, I conclude with a reasonable degree of medical certainty that the aforementioned patient can safely receive the COVID-19 mRNA vaccine.

SIGNATURE

Dr. _____

Date: _____