CVMS Recipient Registration

Recipient Full Name: _____**Date of Birth** _____/_____/_____

Recipient Email Address: _____ ☐ No email

Have you already registered in the COVID-19 Vaccine Portal? ☐ Yes ☐ No

Home Phone Number: _____**Mobile Phone Number:** _____

Address: _____ **City:** _____

Zip Code: _____ **County:** _____**State:** _____

Best way to contact you: ☐ SMS/Text Message ☐ Email ☐ Both ☐ None

Recipient Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Unknown

Recipient Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Recipient Gender: ☐ Male ☐ Female ☐ Other ☐ I do not want to specify

What is your Vaccine Group?

☐ Group 1	☐ Group 2	☐ Group 3	☐ Group 4	☐ Group 5
Health care workers & Long-Term Care staff and residents	*Anyone 65 years or older, regardless of health status or living situation*	*Frontline essential workers*	*Adults at high risk for exposure and increased risk of severe illness*	*Everyone else who wants a safe and effective COVID-19 vaccination*

☐ **I certify that I am**: (a) at least 18 years of age (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to the licensed healthcare provider administering the vaccine, as applicable (each an 'applicable Provider'), to share my personal, demographic and health condition information in order to provide me with vaccination services for the COVID-19 vaccine.

Recipient Signature _____