MEDIC, Inc. 1601 Ailor Avenue Knoxville, TN
COVID-19 Attestation Form

Patient name:____DOB:______________

Address:____

Phone#: Cell___________________________________ Home________________________________

Health Care Professional to Complete/Attest (Mark applicable boxes and provide dates):

1) **Evidence of COVID-19 documented by a laboratory test <u>either</u> by:**

☐ Had positive COVID-19 diagnostic test while ill. Date of positive test:____________________

<u>OR</u>

☐ Had positive serological test for SARS CoV-2 antibodies, after recovery [if diagnostic test was not performed at the time COVID-19 was suspected] Date of positive test: ____________________

2) **<u>AND</u> either of the following:**

☐ Has been symptom-free for more than 28 days prior to donation. Date of last symptom (if known):__________________

<u>OR</u>

☐ Complete resolution of symptoms at least 14 days prior to donation
Date of last symptom (if known):__________________

<u>AND</u>

☐ Negative results for COVID-19 either from one or more nasopharyngeal swab specimens or by a molecular diagnostic test from blood.
Date of negative test: ______________Test performed:_________________

Results provided by (attach test results if available):

☐ Physician (or designee) ☐ Hospital:____________________________ ☐ Health Dept. State:______

____ _____________________________________

Print name of authorized healthcare professional Healthcare professional signature

Provider Contact Phone #:____

SEND TO MEDIC DONOR SERVICES

Fax: 865-521-2649 or Email: contact@medicblood.org

COVID-19 Convalescent Plasma DONOR TO COMPLETE:

Date of Last COVID-19 Symptom:_________________ Phone#:___________MEDIC ID: _____________

____ ____

Print donor name Donor Signature