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 COVID-19 symptoms and ☐ a positive diagnostic test while ill.

Date of positive diagnostic test:_____

<u>OR</u>

☐ Did not have a prior positive diagnostic test and/or never had symptoms, but had positive serological test for SARS CoV-2 antibodies. Date of positive antibody test: _____

2) **<u>AND</u>**

☐ Complete resolution of symptoms at least 14 days prior to donation

Date of last symptom (if known):_____

<u>OR</u>

☐ Never had symptoms

Results provided by (attach test results if available):

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

☐ Other ☐ MEDIC antibody screen

_____ _____

Print name of authorized healthcare professional Healthcare professional signature

Provider Contact Phone #:_____

SEND TO MEDIC DONOR SERVICES
Fax: 865-521-2649 or Email: <u>contact@medicblood.org</u>

COVID-19 Convalescent Plasma DONOR TO COMPLETE:

☐ Had COVID-19 Symptoms **<u>OR</u>** ☐ Never had symptoms

Date of last symptoms:_____

Phone#:_____ MEDIC ID: _____

_____ _____

Print donor name Donor Signature