MEDIC, Inc. 1601 Ailor Avenue Knoxville, TN
Attestation Form for Donation of COVID-19 Convalescent Plasma (CCP)

Patient name:____DOB:_____________

Address:____MEDIC ID:______________

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 #:_________________________

Date form completed: ____________________________

*******SEND TO MEDIC DONOR SERVICES:**

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

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MEDIC USE ONLY: ☐ Diagnostic Test Results Accepted OR ☐ Diagnostic Test Results Not Accepted

Eligible to donate on (date): _______________ (if further checklist/intake is acceptable)

By: _______________ Date: _____________