Recipient Registration and COVID-19 Vaccine Administration Form

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

Recipient Email Address: _____ ☐ No email

Social Security Number: _____

Have you already registered in the CVMS Recipient Portal? ☐ Yes ☐ No

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

Address: _____ **City:** _____

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

What is the name of the organization you work for (or reside in)? _____ ☐ Not employed

If employed, in what industry do you work? (healthcare, food and agriculture, manufacturing, education, etc.)

_____

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

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

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

Do you identify as any of the following?

☐ Frontline essential worker (in person at work)
☐ Other essential worker (non-frontline)
☐ Patient-facing healthcare worker or long-term care facility worker
☐ School and child care frontline essential worker
☐ Resident of a congregate/group setting
☐ Resident of a long-term care facility
☐ Student
☐ None of the above

How many conditions do you have that put you at risk for developing severe illness from COVID-19? ☐ None ☐ 1 ☐ 2 or more

☐ **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 _____

Please complete this section using your insurance card. If you are not insured, you do not need to fill out this information.
INSURANCE INFORMATION/AUTHORIZATION TO BILL (copy of front and back of insurance card preferred for verification)

Insurance Name: _____ Member ID: _____

Group Number: _____ Phone Number: _____

Medical Claims Address: _____

Subscriber Name: _____Subscriber Date of Birth: _____/_____/_____

Subscriber Address: _____

☐ I authorize payment from 3rd Party Payer (Insurance) and Medicare/Medicaid be made on my behalf to the licensed healthcare provider administering the vaccine for services provided. I understand that my signature above will serve as legal "signature on file" for purposes of filing insurance/Medicaid claims and payment of benefits to the licensed healthcare provider administering the vaccine for services rendered.

OFFICE USE ONLY

☐ **Verbal Consent for COVID-19 Vaccine Obtained**

Site of Injection: ☐ Right Deltoid, IM ☐ Left Deltoid, IM ☐Other_____

Dose: ☐ First Dose ☐ Second Dose

Administration Date: _____/_____/_____

Administration Time: _____

COVID-19 Vaccine Manufacturer: _____

Lot #: _____ **Exp:** _____/_____/_____

Manufacturer sticker (optional)

Vaccine administered by (Clinician Name)_____ **Signature**_____

Vaccinating Clinic Name_____

Form Version 8 – 2/11/2021 – North Carolina COVID-19 Vaccine Management System

☐ Entered in CVMS by _____ (name) on _____ (date)

☐ Registered in Patagonia by _____(name) on _____ (date)