GOVERNMENT OF MEGHALAYA
CO-MORBIDITIES CERTIFICATE – COVID 19 VACCINATION

(To be filled by a Registered Medical Practitioner)

Name of beneficiary:

Age: **Gender:**

Address:

Mobile phone number:

Identification document:

I, Dr. _____, working as _____ have reviewed the above named individual and certify that he/she has the below mentioned conditions based on the records presented to me. A copy of the records on which this certificate is based is attached.

Presence of **ANY ONE** of the following criteria will prioritize the individual for vaccination

SN	Criterion	Yes/No
1.	Heart Failure with hospital admission in past one year	
2.	Post Cardiac Transplant/Left Ventricular Assist Device (LVAD)	
3.	Significant Left ventricular systolic dysfunction (LVEF <40%)	
4.	Moderate or Severe Valvular Heart Disease	
5.	Congenital heart disease with severe PAH or Idiopathic PAH	
6.	Coronary Artery Disease with past CABG/PTCA/MI AND Hypertension/Diabetes on treatment	
7.	Angina AND Hypertension/Diabetes on treatment	
8.	CT/MRI documented stroke AND Hypertension/Diabetes on treatment	
9.	Pulmonary artery hypertension AND Hypertension/Diabetes on treatment	
10.	Diabetes (> 10 years OR with complications) AND Hypertension on treatment	
11.	Kidney/ Liver/ Hematopoietic stem cell transplant: Recipient/On wait-list	
12.	End Stage Kidney Disease on haemodialysis/ CAPD	
13.	Current prolonged use of oral corticosteroids/ immunosuppressant medications	
14.	Decompensated cirrhosis	
15.	Severe respiratory disease with hospitalizations in last two years/FEV1 <50%	
16.	Lymphoma/ Leukaemia/ Myeloma	
17.	Diagnosis of any solid cancer on or after 1st July 2020 or currently on any cancer therapy	
18.	Sickle Cell Disease/ Bone marrow failure/ Aplastic Anemia/ Thalassemia Major	
19.	Primary Immunodeficiency Diseases/ HIV infection	
20.	Persons with disabilities due to Intellectual disabilities/ Muscular Dystrophy/ Acid attack with involvement of respiratory system/ Persons with disabilities having high support needs/ Multiple disabilities including deaf-blindness	

I am aware that providing false information is an offence.

Name of RMP:_____

Medical Council registration number of RMP: _____

Date of issuing the certificate: _____

Place of issue: _____ **(Signature of RMP)**