health

Department:
Health
REPUBLIC OF SOUTH AFRICA

ANNEXURE A: COVID-19 VACCINATION:

REQUEST FOR ADMINISTRATION OF ADDITIONAL DOSE

DETAILS OF VACCINEE

Name	
Date of birth	
ID number (or equivalent)	
Address	
Mobile number	
Email	

COVID-19 VACCINATION: DOSES ADMINISTERED TO DATE (if available)

Vaccine:	Date:	Vaccine:	Date:

I,_____, confirm that this individual is eligible to receive an additional dose of Covid vaccine based on the eligibility criteria shown below (insert the name of referring doctor or nurse).

Individuals with the following conditions:
Hematological or immune malignancy
Moderate to Severe Primary immunodeficiency disorder
HIV infection with CD4 count < 200 cells/µL within the last 6 months
Asplenia
Individuals receiving the following treatments:
High dose steroids or systemic biologics (e.g., for autoimmune conditions)
Long term renal dialysis
Transplant recipients (Solid organ or bone marrow)

VACCINE THAT SHOULD BE ADMINISTERED

Name of Vaccine	**Date (if applicable)**

DETAILS OF REQUESTING DOCTOR OR PROFESSIONAL NURSE

Full Name	
HPCSA or SANC annual practicing number	
Institution or practice	
Contact number	
Date	
Signature:	