

**Certification of Medical High-Risk Status under CDC Guidelines**

I certify that \_\_\_\_\_ (employee name) has a medical or underlying condition that puts them at a higher risk for severe illness from COVID-19 under Center for Disease Control’s guidelines.

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*To Be Completed by Health Care Provider*

\_\_\_\_\_  
Name of Health Care Provider (Please Print)

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date