CHRISTOPHER NEWPORT
UNIVERSITY

MEDICAL VERIFICATION FORM
VERIFIED HIGH RISK FOR SEVERE ILLNESS (COVID-19)
August 1, 2020 – June 30, 2021

To: Director of Human Resources

Name of Physician (please print or type): _____

Office Address: _____

City, State and Zip Code: _____

Patient Name: _____

By signing below, I confirm that I am treating this patient who is at an increased risk of severe illness from COVID-19 due to one of the following health conditions identified by the Centers for Disease Control.

(There is no need to identify the specific condition.)

- Chronic kidney disease
- COPD (Chronic obstructive pulmonary disease)
- Immunocompromised state (weakened immune system) for solid organ transplant
- Obesity (body mass index [BMI] of 30 or higher)
- Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Sickle cell disease
- Type 2 diabetes mellitus

Physician Signature: _____ Date: _____

Office of Human Resources
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