

GRANT COUNTY HEALTH DEPARTMENT
528 E MAIN ST SUITE E
JOHN DAY, OR 97845

NAME (Please Print): _____ Male _____ Female _____ Other _____

BIRTH DATE: _____ **MARITAL STATUS:** Single _____ Married _____ Divorced _____ Widowed _____

RACE: American Indian/Alaskan Native _____ Asian _____ Black/African American _____
Hispanic/Latino _____ Native Hawaiian/Pacific Islander _____ White _____ Other _____

ETHNICITY: Hispanic _____ Non-Hispanic _____ **LANGUAGE:** English _____ Spanish _____
Other(specify) _____

SOCIAL SECURITY #: _____ **VETERAN:** Yes _____ No _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PHONE NUMBER: _____ **EMAIL:** _____

HOW DO YOU PREFER TO BE CONTACTED: Email _____ Text _____ MyChart _____

MAY WE LEAVE A MESSAGE AT THE NUMBERS LISTED: Yes _____ No _____

USUAL DOCTOR: _____ **PHARMACY:** _____

ALLERGIES: _____

GROSS FAMILY INCOME (monthly income before taxes): _____

**** We ask for your income information so we can apply a sliding fee if you are income eligible****

NUMBER OF PEOPLE IN THE HOUSEHOLD: _____

EMPLOYMENT: Full Time _____ Part Time _____ Seasonal _____ Unemployed _____ Retired _____ Disabled _____

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP:** _____

EMERGENCY CONTACT PHONE NUMBER: _____

INSURANCE CARRIER: _____

POLICY #: _____ **GROUP #:** _____

CONTACT INFORMATION OF INSURANCE SUBSCRIBER IF DIFFERENT FROM PATIENT:

NAME: _____ **DATE OF BIRTH:** _____ **PHONE:** _____



Grant County Health Department

COMMUNITY COUNSELING SOLUTIONS
Changing Lives

KIMBERLY LINDSAY, ADMINISTRATOR

Consent for Services

I am voluntarily applying to the Grant County Health Department for services – this may include reproductive health services and/or primary care services. I understand:

- I may receive medical care that involves follow up testing and treatment;
- Arranging for these tests and treatments are my responsibility;
- Necessary follow-up care for abnormal findings will be my responsibility when referred from this agency to a physician or other health care provider;
- That all services will be explained and I can ask questions;
- I may be given information about birth control methods;
- I can ask questions and refuse any birth control method I do not want to use;
- Reproductive Healthcare Services will not be refused if I owe money from other visits types;
- Services do not include 24-hour care, and in case of a medical emergency, I will need to go to an emergency room and pay its costs.

Services could include, but are not limited to, the following:

- Reproductive health counseling on birth control, getting pregnant, healthy pregnancies and other subjects as needed.
- Sexually transmitted disease exams and treatment.
- Pap smears and physical exams for women.
- Hemoglobin, hematocrit, glucose, hemoglobin A1C screening and urine microalbumin.
- Urinalysis.
- Pregnancy, testing and referral.
- Physical exams for children, adults and the elderly including CDL and sports physicals
- WIC services.
- Primary care including preventive services, treatment of acute and chronic illnesses or disease and education about personal medical issues
- Dental assessment to include fluoride varnish when appropriate
- Referral for services when indicated

Fees for services are based on a sliding fee schedule provided by Oregon State Health Division. The amount you pay is determined by your family's gross monthly income, and the number of people in your family. We will bill most insurance. Reproductive Health Clients will not be denied services or subjected to any variation in the quality of services based on their inability to pay. Priority for reproductive health (RH) services will be given to persons from low-income families and others who may have difficulty accessing services, but is not limited to this population. No durational residency requirements will be allowed in the provision of RH services.

All services and communication you receive here are confidential, except in the following circumstances:

- In the instance of child abuse.
- In the instance of statutory rape.
- In the instance when a court of law issues a subpoena for medical records.
- When there are positive HIV results for a minor.
- In the instance of a reportable disease, Grant County Health Department will be required to report it to Oregon State Public Health.

*Explanations of the above circumstances are available upon request

Grant County Health Department is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Grant County Health Department, OCHIN supplies information technology and related services to Grant County Health Department and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Grant County Health Department with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

I have received a notice of privacy practices and questions I have about the privacy practices of Grant County Health Department have been answered to my satisfaction. By my signature I acknowledge I understand and agree with all issues addressed above.

I, (print my name) _____, have read and understand the above information, and consent to receive health services from the Grant County Health Department.

Client Signature

Date

Witness

Interpreter Signature

Date

These questions are optional and your answers are confidential. We would like you to tell us your race, ethnicity, language and ability levels so that we can find and address health and service differences.

You can get this document in other languages, large print, braille, or a format you prefer. We accept all relay calls or you can dial 711. Please contact _____ at _____

Today's Date: _____ Medical record number (if applicable): _____

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Race and Ethnicity

1. How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry?**

2. Which of the following describes your **racial or ethnic identity?** Please check **ALL** that apply.

Hispanic and Latino/a/x

- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Native Hawaiian and Pacific Islander

- ☐ CHamoru (Chamorro)
- ☐ Marshallese
- ☐ Communities of the
Micronesia Region
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

White

- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

American Indian and Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or
First Nation
- ☐ Indigenous Mexican, Central
American, or South American

Black and African American

- ☐ African American
- ☐ Afro-Caribbean
- ☐ Ethiopian
- ☐ Somali
- ☐ Other African (Black)
- ☐ Other Black

Middle Eastern/North African

- ☐ Middle Eastern
- ☐ North African

Asian

- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Communities of Myanmar
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Other categories

- ☐ Other (please list)

- ☐ Don't know

- ☐ Don't want to answer

3. If you checked **more than one** category above, is there **one** you think of as your **primary** racial or ethnic identity?

- ☐ Yes. Please circle your primary racial or ethnic identity above.
- ☐ I do not have just one primary racial or ethnic identity.
- ☐ No. I identify as Biracial or Multiracial.
- ☐ N/A. I only checked one category above.
- ☐ Don't know
- ☐ Don't want to answer

(To be filled in by agency or clinic staff)

Agency or clinic: _____ Agency staff or provider name or ID: _____

Phone: _____ Address: _____

Language (*Interpreters are available at no charge*)4a. What language or languages do you **use at home**? _____**Skip to question 7 if you indicated English only**4b. In what language do you want us to communicate in **person, on the phone, or virtually** with you?
_____4c. In what language do you want us to **write** to you? _____5a. Do you need or want an **interpreter** for us to communicate with you?☐ Yes ☐ No ☐ Don't know ☐ Don't want to answer

5b. If you need or want an interpreter, what type of interpreter is preferred?

- ☐ Spoken language interpreter ☐ Deaf Interpreter for DeafBlind, additional barriers, or both
- ☐ American Sign Language interpreter ☐ Contact sign language (PSE) interpreter
- ☐ Other (***please list***): _____

Skip to question 7 if you do not use a language other than English or sign language

6. How well do you speak English?

☐ Very Well ☐ Well ☐ Not Well ☐ Not at all ☐ Don't know ☐ Don't want to answer

Your answers will help us find health and service differences among people with and without functional difficulties. Your answers are confidential. (**Please write in "don't know" if you don't know when you acquired this condition, or "don't want to answer" if you don't want to answer the question.*)

Yes	*If yes, at what age did this condition begin?	No	Don't know	Don't want to answer	Don't know what this question is asking
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7. Are you **deaf** or do you have **serious difficulty hearing**?8. Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?**Please stop now if you/the person is under age 5**9. Do you have **serious difficulty walking or climbing stairs**?10. Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?11. Do you have **difficulty dressing or bathing**?12. Do you have **serious difficulty learning how to do things most people your age can learn**?13. Using your **usual (customary) language**, do you have **serious difficulty communicating** (*for example understanding or being understood by others*)?**Please stop now if you/the person is under age 15**14. Because of a **physical, mental or emotional condition**, do you have **difficulty doing errands alone** such as visiting a doctor's office or shopping?15. Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?



Grant County Health Department

COMMUNITY COUNSELING SOLUTIONS
Changing Lives

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**FACT SHEET FOR RECIPIENTS AND CAREGIVERS
EMERGENCY USE AUTHORIZATION (EUA) OF
THE MODERNA COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019
(COVID-19) IN INDIVIDUALS 18 YEARS OF AGE AND OLDER**

You are being offered the Moderna COVID-19 Vaccine to prevent Coronavirus Disease 2019 (COVID-19) caused by SARS-CoV-2. This Fact Sheet contains information to help you understand the risks and benefits of the Moderna COVID-19 Vaccine, which you may receive because there is currently a pandemic of COVID-19.

The Moderna COVID-19 Vaccine is a vaccine and may prevent you from getting COVID-19. There is no U.S. Food and Drug Administration (FDA) approved vaccine to prevent COVID-19.

Read this Fact Sheet for information about the Moderna COVID-19 Vaccine. Talk to the vaccination provider if you have questions. It is your choice to receive the Moderna COVID-19 Vaccine.

The Moderna COVID-19 Vaccine is administered as a 2-dose series, 1 month apart, into the muscle.

The Moderna COVID-19 Vaccine may not protect everyone.

This Fact Sheet may have been updated. For the most recent Fact Sheet, please visit www.modernatx.com/covid19vaccine-eua.

WHAT YOU NEED TO KNOW BEFORE YOU GET THIS VACCINE

WHAT IS COVID-19?

COVID-19 is caused by a coronavirus called SARS-CoV-2. This type of coronavirus has not been seen before. You can get COVID-19 through contact with another person who has the virus. It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have had a wide range of symptoms reported, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to the virus. Symptoms may include: fever or chills; cough; shortness of breath; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

WHAT IS THE MODERNA COVID-19 VACCINE?

The Moderna COVID-19 Vaccine is an unapproved vaccine that may prevent COVID-19. There is no FDA-approved vaccine to prevent COVID-19.

The FDA has authorized the emergency use of the Moderna COVID-19 Vaccine to prevent COVID-19 in individuals 18 years of age and older under an Emergency Use Authorization (EUA).

For more information on EUA, see the “**What is an Emergency Use Authorization (EUA)?**” section at the end of this Fact Sheet.

WHAT SHOULD YOU MENTION TO YOUR VACCINATION PROVIDER BEFORE YOU GET THE MODERNA COVID-19 VACCINE?

Tell your vaccination provider about all of your medical conditions, including if you:

- have any allergies
- have a fever
- have a bleeding disorder or are on a blood thinner
- are immunocompromised or are on a medicine that affects your immune system
- are pregnant or plan to become pregnant
- are breastfeeding
- have received another COVID-19 vaccine

WHO SHOULD GET THE MODERNA COVID-19 VACCINE?

FDA has authorized the emergency use of the Moderna COVID-19 Vaccine in individuals 18 years of age and older.

WHO SHOULD NOT GET THE MODERNA COVID-19 VACCINE?

You should not get the Moderna COVID-19 Vaccine if you:

- had a severe allergic reaction after a previous dose of this vaccine
- had a severe allergic reaction to any ingredient of this vaccine

WHAT ARE THE INGREDIENTS IN THE MODERNA COVID-19 VACCINE?

The Moderna COVID-19 Vaccine contains the following ingredients: messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose.

HOW IS THE MODERNA COVID-19 VACCINE GIVEN?

The Moderna COVID-19 Vaccine will be given to you as an injection into the muscle.

The Moderna COVID-19 Vaccine vaccination series is 2 doses given 1 month apart.

If you receive one dose of the Moderna COVID-19 Vaccine, you should receive a second dose of the same vaccine 1 month later to complete the vaccination series.

HAS THE MODERNA COVID-19 VACCINE BEEN USED BEFORE?

The Moderna COVID-19 Vaccine is an unapproved vaccine. In clinical trials, approximately 15,400 individuals 18 years of age and older have received at least 1 dose of the Moderna COVID-19 Vaccine.

WHAT ARE THE BENEFITS OF THE MODERNA COVID-19 VACCINE?

In an ongoing clinical trial, the Moderna COVID-19 Vaccine has been shown to prevent COVID-19 following 2 doses given 1 month apart. The duration of protection against COVID-19 is currently unknown.

WHAT ARE THE RISKS OF THE MODERNA COVID-19 VACCINE?

Side effects that have been reported with the Moderna COVID-19 Vaccine include:

- Injection site reactions: pain, tenderness and swelling of the lymph nodes in the same arm of the injection, swelling (hardness), and redness
- General side effects: fatigue, headache, muscle pain, joint pain, chills, nausea and vomiting, and fever

There is a remote chance that the Moderna COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Moderna COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

These may not be all the possible side effects of the Moderna COVID-19 Vaccine. Serious and unexpected side effects may occur. The Moderna COVID-19 Vaccine is still being studied in clinical trials.

WHAT SHOULD I DO ABOUT SIDE EFFECTS?

If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to **FDA/CDC Vaccine Adverse Event Reporting System (VAERS)**. The VAERS toll-free number is 1-800-822-7967 or report online to <https://vaers.hhs.gov/reportevent.html>. Please include “Moderna COVID-19 Vaccine EUA” in the first line of box #18 of the report form.

In addition, you can report side effects to ModernaTX, Inc. at 1-866-MODERNA (1-866-663-3762).

You may also be given an option to enroll in **v-safe**. **V-safe** is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. **V-safe** asks questions that help CDC monitor the safety of COVID-19 vaccines. **V-safe** also provides second-dose reminders if needed and live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.

WHAT IF I DECIDE NOT TO GET THE MODERNA COVID-19 VACCINE?

It is your choice to receive or not receive the Moderna COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care.

ARE OTHER CHOICES AVAILABLE FOR PREVENTING COVID-19 BESIDES MODERNA COVID-19 VACCINE?

Currently, there is no FDA-approved alternative vaccine available for prevention of COVID-19. Other vaccines to prevent COVID-19 may be available under Emergency Use Authorization.

CAN I RECEIVE THE MODERNA COVID-19 VACCINE WITH OTHER VACCINES?

There is no information on the use of the Moderna COVID-19 Vaccine with other vaccines.

WHAT IF I AM PREGNANT OR BREASTFEEDING?

If you are pregnant or breastfeeding, discuss your options with your healthcare provider.

WILL THE MODERNA COVID-19 VACCINE GIVE ME COVID-19?

No. The Moderna COVID-19 Vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.


KEEP YOUR VACCINATION CARD

When you receive your first dose, you will get a vaccination card to show you when to return for your second dose of the Moderna COVID-19 Vaccine. Remember to bring your card when you return.

ADDITIONAL INFORMATION

If you have questions, visit the website or call the telephone number provided below.

To access the most recent Fact Sheets, please scan the QR code provided below.

Moderna COVID-19 Vaccine website	Telephone number
www.modernatx.com/covid19vaccine-eua 	1-866-MODERNA (1-866-663-3762)

HOW CAN I LEARN MORE?

- Ask the vaccination provider
- Visit CDC at <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- Visit FDA at <https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization>
- Contact your state or local public health department

WHERE WILL MY VACCINATION INFORMATION BE RECORDED?

The vaccination provider may include your vaccination information in your state/local jurisdiction's Immunization Information System (IIS) or other designated system. This will ensure that you receive the same vaccine when you return for the second dose. For more information about IISs, visit: <https://www.cdc.gov/vaccines/programs/iis/about.html>.

WHAT IS THE COUNTERMEASURES INJURY COMPENSATION PROGRAM?

The Countermeasures Injury Compensation Program (CICP) is a federal program that may help pay for costs of medical care and other specific expenses of certain people who have been seriously injured by certain medicines or vaccines, including this vaccine. Generally, a claim must be submitted to the CICP within one (1) year from the date of receiving the vaccine. To learn more about this program, visit www.hrsa.gov/cicp/ or call 1-855-266-2427.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?

The United States FDA has made the Moderna COVID-19 Vaccine available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Services (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

The Moderna COVID-19 Vaccine has not undergone the same type of review as an FDA-approved or cleared product. FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, and available alternatives. In addition, the FDA decision is based on the totality of the scientific evidence available showing that the product may be effective to prevent COVID-19 during the COVID-19 pandemic and that the known and potential benefits of the product outweigh the known and potential risks of the product. All of these criteria must be met to allow for the product to be used during the COVID-19 pandemic.

The EUA for the Moderna COVID-19 Vaccine is in effect for the duration of the COVID-19 EUA declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

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Patent(s): www.modernatx.com/patents

Revised: 12/2020

