THE BLOOD CONNECTION
Your Community Blood Center

Provider Attestation Form

The individual named below is being referred for consideration of COVID-19 convalescent plasma donation.

Patient/Donor Full Name ______________________

City, State ______________________

Date of Birth ______________________

Phone Number ______________________

Email Address ______________________

I attest that the above-named individual has:

Evidence of COVID-19 documented by a laboratory test either by:

☐ A positive diagnostic test (e.g., nasopharyngeal swab) at the time of illness

Date of Test ______________________

OR

☐ A positive serological test for SARS-CoV-2 antibodies after recovery, if prior diagnostic testing was not performed at the time COVID-19 was suspected

Date of Test ______________________

AND Either one of the following (please check a relevant box):

☐ Complete resolution of symptoms at least 28 days prior to donation

OR

☐ Complete resolution of symptoms at least 14 days prior to donation, AND Negative results for COVID-19 either from one or more nasopharyngeal swab specimens or by a molecular diagnostic test from blood.

Date of Negative Test ______________________

Physician Full Name ______________________

Hospital Provider ______________________

Signature ______________________

Date ______________________

Please send this completed form to **ProductionPlanningSchedulers@thebloodconnection.org or to the patient/donor**. If the patient is unable to obtain this form in hand, the provider will fax on his/her behalf.

Please call **(864) 751-1168** with any questions you may have.