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 _____

AND

☐ Complete resolution of symptoms at least 14 days prior to donation

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

☐ Complete resolution of symptoms at least 14 days prior to donation

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.