



Recipient Registration Form



Fields with an * are required

*First Name

*Last Name

*Street Address

*Town/City/State/Zip or Postal Code

Phone Number

Cell Phone

*Gender

- Female
- Male
- Decline to Specify
- Other

*Date of Birth *Click or tap to enter a date.*

*Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown/Not Reported

*Race (Please check all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Unknown/Not Reported



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Emergency Contact Name

Emergency Contact Number

*** I am currently living in a nursing home**

- Yes
- No

*** Select Priority Group**

- Adult with comorbidities or other medical conditions
- Age 65 and older
- Deployed and mission critical personnel for national security
- Education sector personnel
- Emergency service and public safety sector personnel
- Food & agriculture & transportation sector personnel
- Health care providers in long term care facilities (LTCFs)
- Inpatient healthcare providers
- Live with or care for adult 65 and older
- Long term care facility residents
- Manufacturers of pandemic vaccine and other critical pandemic therapeutics
- National Guard personnel
- Other congregate living facility residents
- Other priority groups
- Pharmacists and pharmacy technicians (Retail)
- Public health personnel

*** Organization Name**

Organization Street Address

Organization City/Town, State, Zip Code