HOW TO CREATE AN ACCOUNT & SCHEDULE AN APPOINTMENT FOR VACCINATION INSTRUCTIONS

Create an Account:

Step 1: Visit www.Patientportalfl.com

Step 2: Click “Create an Account”
Step 3: Complete the **Registration Form** to **Create your Account**

a. Enter the **Basic Information**: First Name, Last Name, Date of Birth, Phone, Email, Username and Password (*if using the same email address to create multiple accounts, please make sure the username is unique to each account.*)

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**FAST, ACCURATE, CONVENIENT.**

**Basic Info**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>karen</td>
</tr>
<tr>
<td>Last Name</td>
<td>ztest1233</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>02/20/1945</td>
</tr>
<tr>
<td>Phone (for calls)</td>
<td>3055555555</td>
</tr>
</tbody>
</table>

*This is an International Phone Number
- Opt in to SMS (Text) notifications
- Mobile Same As Phone

For additional assistance, please contact covid19support@cdrmhealth.com
b. Enter Home Address: County, Street, City, State, Postal Code
c. Enter the **Demographics**: Gender, Race, Ethnicity, Do you live in house with 2 or more people? Occupation, Are you qualified as Disable? Are you considered Medically Vulnerable?*

*you must answer **No** to the Medically Vulnerable question in order to make an appointment.
d. **Enter Insurance Information:** Primary Billing Insurance, Primary Insurance Carrier, Policy ID No., Group No., Insurance Guarantor, Social Security Number

*(Patients can “Decline to Answer” or select from the drop-down options – No insurance available.)*
e. Acknowledgements:

In order to use the CDR Maguire App you must make certain acknowledgments.

Logging in to your Account acts as a legally binding signature, same as your handwritten signature on a paper document, and confirms that

* I am (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the patient and confirm that the patient is at least 12 years of age; or (c) authorized to consent for the patient named above.

* I have read and understood the information provided.

* I have read and understand and will abide by the CDR Maguire Terms and Conditions, Privacy Policy, and HIPAA Privacy. I hereby provide my express consent and authorization to release my personal health information, including any COVID-19 test results, to this account I have created and anyone who logs in using my credentials going forward.

* I have read and understand my waiver of liability on the Ordering Provider.

* I agree to and provide Authorization for Use of PHI.

* I provide my Consent for CDR to Contact.

Sign Up

Previous
SCHEDULE AN APPOINTMENT

After creating your account, the system will automatically open to the Home Page of the Patient Portal

a. Click “Get Vaccinated”
b. **How would you like to proceed?**
   - Select schedule an appointment
   - Select Next

   ![Image of form options]

   *How would you like to proceed?*
   - [ ] Schedule an appointment*
   - [ ] Walk-Up without an appointment
   - [ ] In-Home Appointment

   [Next]

   ![Image of form options]

   *Do you have an entry code?*
   - [ ] Yes
   - Input entry code (FSU EMAIL)
   - Select Next

   ![Image of form options]

   Do you have an Entry Code?

   [ ] No  [ ] Yes

   Please input your entry code

   ![Redacted entry code]

   [Next]
d. Get Vaccinated:

Please note that the system will allow you to create an appointment for a first dose if you answer No to "Have you received an initial dose of Covid19 vaccination?"

- Please answer all the questions below if you are making an appointment for a booster vaccination
- Select Next
- If you are eligible based on the CDC Criteria for occupations please answer yes to the "Do you have increased risk for COVID-19 exposure and transmission because of occupational or institutional settings?" Question

Get Vaccinated

- Have you previously received an initial dose of COVID19 vaccination?
  - Yes

- *Vaccine Manufacturer
  - Pfizer
  - Moderna
  - Janssen (J&J)

- *Have you completed your second dose?
  - No
  - Yes

- *Are you moderately to severely immunocompromised or are on a medicine that affects your immune system (e.g. solid organ transplant recipient, immunosuppressant medications, active treatment for cancer, etc.)?
  - No
  - Yes

- *Do you reside in a long-term care facility?
  - No
  - Yes

- *Do you have underlying medical condition(s)?
  - No
  - Yes

- *Do you have increased risk for COVID-19 exposure and transmission because of occupational or institutional setting?
  - No
  - Yes

*Most Recent Lot Number

SSSSS

*Most Recent Previous Covid vaccination date

Mar 1, 2021

Please bring your CDC vaccination card with you to your vaccination appointment.

For additional assistance, please contact covid19support@cdrmhealth.com
Consent and Liability Release:

- Read and sign below
- Select Next

COVID-19 Consent and Liability Release

In consideration of receiving a COVID-19 vaccine or a COVID-19 booster (herein referred to as the “vaccine”) I, by signing this COVID-19 Vaccine Consent and Liability Release (the “Consent and Release”) or by providing verbal consent to the registration or medical personnel at the vaccination site, agree and attest as follows:

- I certify that I am: (a) the patient and at least 18 years of age, (b) the parent or legal guardian of the patient and confirm that the patient is at least 12 years of age (for Pfizer vaccine consent only), or (c) legally authorized to consent for vaccination for the registered patient. Further, I hereby give my consent to CDR Health Care Inc., CDR Maguire Inc., the Department of Health (DOH) and other state entities involved in the administration of the vaccine to myself or to the registered patient (the “Authorized Parties”).

- I certify that all the information provided, including medical history, is accurate and correct.

- I understand that currently, Pfizer is the only vaccine product that has been fully approved and licensed by FDA. This FDA approval and license is for use in individuals 16 years of age and older only. I understand that the vaccine (other than Pfizer for usage in ages mentioned above only) has not been approved or licensed by FDA, but has been authorized for emergency use by FDA, under an EUA to prevent Coronavirus Disease 2019 (COVID-19) for use in individuals either 12-15 years of age (Pfizer only) or 16 years of age and older (Moderna and Johnson and Johnson), and the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of the medical product under Section 564(b)(1) of the FD&C Act unless the declaration is terminated or authorization revoked sooner.

- I understand that it is not possible to predict all possible risks, side effects, or complications associated with receiving the vaccine. I acknowledge and agree that I have received, read, and/or had explained the risks and benefits associated with receiving the vaccine and that thereafter, I have elected to receive the vaccine. I also acknowledge that I have had a chance to ask questions about the vaccine and that such questions and that such questions were answered to my satisfaction.

- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.

- I acknowledge receipt of and agree to the patientportal.com Terms and Conditions, Privacy Policy, HIPAA Privacy Notice and hereby provide my consent and authorization to release my personal health information.

- I consent to be contacted by Authorized Parties in the future to offer me additional services and information, including but not limited to clinical services and voluntary participation in research studies.

- I understand that I may be assigned an authorized provider for the purpose of receiving the vaccine and understand that such authorized provider assigned to me for such purposes and listed as an authorized provider will serve the sole and limited purpose of authorizing the administration of my vaccine and that such authorized provider is not my physician or healthcare professional for any other purpose and is not required to and shall not provide me with any healthcare services or provide any follow-up care.

- Signature of Patient or Authorized Representative:

  By signing below, I attest that: (1) I have read the entire Consent and Release and understand its contents; (2) I am at least eighteen 18 years old and fully competent and legally authorized to sign, on behalf of myself, or on behalf of the registered patient; and (3) my signature (or verbal attestation) is of my own free will and voluntary without any inducement.

☐ This form was completed by someone other than the registered patient and consents were obtained verbally. If so, please write your name in the signature box below.

Sign Here

Clear

Next

For additional assistance, please contact covid19support@cdrmhealth.com
f. Past Medical History

- Check all items that apply to your medical history
- Select Next
g. **Family Medical History**
   - Check all items that apply to your medical history
   - Select Next

<table>
<thead>
<tr>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia</td>
</tr>
<tr>
<td>Arthritis</td>
</tr>
<tr>
<td>Bleeding or clotting abnormality</td>
</tr>
<tr>
<td>Breast disease</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Connective tissue disorder</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Heart disease</td>
</tr>
<tr>
<td>High blood pressure</td>
</tr>
<tr>
<td>High cholesterol</td>
</tr>
<tr>
<td>Mental illness</td>
</tr>
<tr>
<td>Migraines/headaches</td>
</tr>
<tr>
<td>Stroke</td>
</tr>
<tr>
<td>Substance abuse</td>
</tr>
<tr>
<td>Thyroid disorder</td>
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</tbody>
</table>

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h. **Relevant Medical History**

- Select Yes or No to your medical history questions
- Select Next

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*Do you have a history of severe allergic reactions (i.e., anaphylaxis) to the COVID-19 Vaccine or any component (e.g., polyethylene glycol [PEG]) of the COVID-19 Vaccine?*  
- [ ] No  
- [ ] Yes

*Have you had any COVID-19 Antibody therapy within the last 90 days (e.g., Regeneron, Bamlanivimab, COVID Convalescent Plasma, etc.)?*  
- [ ] No  
- [ ] Yes

*Do you have a history of severe allergic reactions (i.e., anaphylaxis) to other vaccines or other injectable medications (not including the COVID-19 vaccine)?*  
- [ ] No  
- [ ] Yes

*Do you have any allergies or have you had an allergic reaction to a substance not related to vaccines or other injectable therapies, like for example, a food, pet, oral medication, environmental allergies, etc.?*  
- [ ] No  
- [ ] Yes

*Are you pregnant or plan to become pregnant? (Understanding that there is no strong evidence on how the vaccine affects pregnancy, please confirm you are ok to proceed).*  
- [ ] No  
- [ ] Yes

*Are you breastfeeding? (Understanding that there is no strong evidence on how the vaccine affects lactating women nor on the effects of mRNA vaccines on the breastfed infant or on milk production/excretion, please confirm you are ok to proceed).*  
- [ ] No  
- [ ] Yes

*Do you have a bleeding disorder or are you on a blood thinner? (Blood Thinners DO NOT INCLUDE the following: any Antiplatelet Agents such as: Plavix, Effient, Aspirin and Brillinta).*  
- [ ] No  
- [ ] Yes

*Are you immuno-compromised or are on a medicine that affects your immune system?*  
- [ ] No  
- [ ] Yes

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i. Pop Up screen will appear.
   - Read and select Next

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Based on your answers you are very high risk for this vaccine. However, in order to ensure your safety, the CDC recommends an observation time after the vaccine is given. For your safety, you will be required to wait an additional 30 minutes of observation.
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j. Select your location:
   - Select Next

If you receive the message below you need to go back to "My Information", click Edit and change your answer to the "Are you considered Medically Vulnerable?" question as referenced in page 4. You must select No to this question to receive an appointment. "My Information" can be found under the icon. After you change the information then return to "Get Vaccinated" and type the entry code again.

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Patients that are medically vulnerable to COVID-19 are currently not able to be vaccinated at this location.

Press Previous to go back and select a different location.
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For additional assistance, please contact covid19support@cdrmhealth.com
k. Select an appointment date and time
   • Select date from dropdown
   • Select time slot

l. Review your appointment selection
   • Select confirm selection

Please review your appointment selection below.
Press CANCEL to select another date and time.

Additional Vaccine
October 11, 2021
1:00 PM - 1:15 PM

FSU Health and Wellness Center - V
960 Learning Way
m. Once the appointment is confirmed screen will appear with appointment details and QR code. If you are scheduling a first dose your second dose appointment will be automatically paired.

Thank you for scheduling your COVID-19 Vaccination Appointment. Please print this page, or take a screenshot, and show the QR code below during your scheduled appointment time at the vaccination site.

You will need this QR code to check-in at the site.

Additional Vaccine

CDR07830783
Carrie Iaals
PID-04085461

October 11, 2021 2:30 PM - 2:45 PM
FSU Health and Wellness Center - V
960 Learning Way
Tallahassee, FL 32306

For additional assistance, please contact covid19support@cdrmhealth.com