**COVID-19 CONVALESCENT PLASMA DONOR FORM**

**Donor Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | |
| Name **(legal name as listed on ID, e.g., driver’s license):** | | | | | | |  | | | | | |  |
|  | | | | | | | | | | | | | |
| Phone #: | |  | | | Email contact: |  | | | Date of Birth: | | |  |  |
|  | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | |
| City/State/Zip: | | |  | | | ⌦ Positive SARS-CoV-2 Test Date: | | | | |  | |  |
|  | | | | | | | | | | | | |  |
| ⌦ First Symptom Date: | | | |  | | | | ⌦ Last Symptom Date: | |  | | |  |
|  | | | | | | | | | | | | | |

**DONOR REQUIREMENTS – Please confirm *each* of the following**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | | |
| ⌦ | | | Vitalant health history criteria have been reviewed by me (or under my supervision) with the donor who has been determined to be eligible | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | |
| ⌦ | | | The donor had  prior laboratory-confirmed COVID-19 diagnosis or  has demonstrable SARS-CoV-2 antibody, has been completely symptom-free for  14-27 days, or  ≥ 28 days and is no longer infectious | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | |
|  | **You MUST attach the following test result:** | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | |
| ⌦ | | | | | | Nasopharyngeal swab, negative for SARS-CoV-2 for all donors, regardless of symptom-free interval | | | | | | | |  |
|  | | | |  | | | | | |  | |  | |  |
|  | **If you have obtained antibody results for any reason, please attach the following results:** | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | |
|  | | ⌦ SARS-CoV-2 antibody titer (please indicate:  IgM  IgG  Neutralizing Ab) | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | |
|  | | | | | If not obvious from the form, titer result is: | | | | |  | | | |  |
|  | | | | | | | | | | | | | | |
|  | | | | | Testing system: | |  | | | | | | |  |
|  | | | | | | | | | | | | | | |
|  | **I certify each of the above by checking all appropriate boxes** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | **Physician/licensed HCP signature:** | | | | | | | | |  | | Date: | |  |  |
|  |  | | | | | | | | | | | | | | |
|  | **Printed name of signatory:** | | | | | | | |  | | | | | |  |
|  |  | | | | | | | | | | | | | | |

**Donor Evaluation Physician or Licensed Healthcare Provider Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | | |  |
| Name: |  | | |  | | |
|  | | | | | |  |
| Monitored email: | |  | 24/7 Phone Contact #: | |  |  |
|  | | | | | |  |

**Facility Information *(complete only if blood products will be shipped to a specific hospital)***

|  |  |  |  |
| --- | --- | --- | --- |
|  | | |  |
| Facility Name: | |  |  |
|  | | |  |
| Address: |  | |  |
|  | | |  |
| City/State/Zip: | |  |  |
|  | | |  |

* **Please email completed form and required test results to** [**ScheduleCovidFree@vitalant.org**](mailto:ScheduleCovidFree@vitalant.org)**. A Vitalant staff member will call the donor to schedule an appointment. Donors *cannot* schedule themselves through the usual online process.**
* **For questions, please call 1-866-CV-PLSMA (866-287-5762).**

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| --- | --- | --- | --- |
| **VITALANT Reviewer Signature:** |  | **Date:** |  |