DR. RAJENDRA PRASAD CENTRAL AGRICULTURAL UNIVERSITY
PUSA, SAMASTIPUR-848 125, BIHAR

No. 994 /Regr/RPCAU, Pusa, the 2nd March, 2021

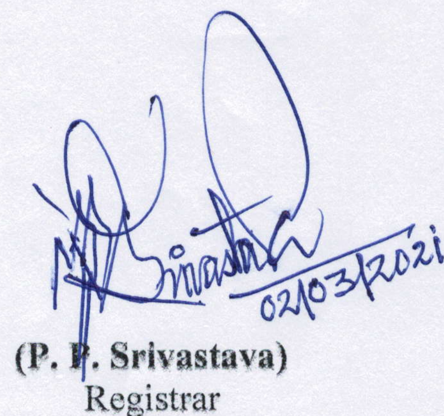
OFFICE MEMORANDUM

Consequent upon the grave situation of Covid-19, there is an opportunity to take the dose of vaccine, at our hospital, supplied by the Government Department. In the first phase, people of the age of 60 years and above will be given vaccination dose alongwith the family member aged 60 years and above. Those who are interested to take the dose are advised to give their details (copy of Aadhaar card and Univ. ID) and willingness to take the vaccine shot. It is further to inform that the 2nd phase will be for 45-60 years aged officials and their family members of same age group with a declaration of any disease suffered by them in last few years.

This may be given top priority for your and your family health welfare and submit details before 4th March, 2021, so that we can organize the vaccination programme at an early.

Best Regards,

Encl: Proforma



(P. P. Srivastava)
Registrar

Copy for information and necessary action to :

1. Hon'ble Vice-Chancellor, RPCAU, Pusa for information through Secretary.
2. All Deans/Directors/Comptroller/Associate Director Research, RPCAU, Pusa
3. University Librarian, RPCAU, Pusa for information.
4. All Heads of the Departments, RPCAU, Pusa
5. All Head, KVKs, RPCAU, Pusa
6. Controlling Officer, APRI, Pusa
7. Executive Engineer, Civil/Electrical, RPCAU, Pusa
8. Officer-in-Charge, EE&EC/ Dy. Registrar (Establishment), Dy. Registrar (Academics), Dy. Registrar (Recruitment), RPCAU, Pusa
9. Chief Medical Officer, University Hospital, RPCAU, Pusa
10. Officer-in-charge, Pusa Farm/ARIS Cell/Central Store/Security/Guest house/Central Workshop/Esate Officer, RPCAU, Pusa
11. O/I, ARIS Cell for uploading the same on all notice Boards
12. Guard File

Annexure 1(B): Certificate to identify individuals with co-morbidities that enhance the risk of mortality in COVID-19 disease for priority vaccination

(To be filled by a Registered Medical Practitioner)

Name of beneficiary: ______________________________

Age: __________ Gender: ______________________________

Address: ______________________________

Mobile phone number: ______________________________

Identification document: ______________________________

I, Dr. ______________________________, working as ______________________________ have reviewed the above named individual and certify that he/she has the below mentioned conditions based on the records presented to me. A copy of the records on which this certificate is based is attached.

Presence of ANY ONE of the following criteria will prioritize the individual for vaccination

SN	Criterion	Yes/No
1.	Heart Failure with hospital admission in past one year	
2.	Post Cardiac Transplant/Left Ventricular Assist Device (LVAD)	
3.	Significant Left ventricular systolic dysfunction (LVEF <40%)	
4.	Moderate or Severe Valvular Heart Disease	
5.	Congenital heart disease with severe PAH or Idiopathic PAH	
6.	Coronary Artery Disease with past CABG/PTCA/MI AND Hypertension/Diabetes on treatment	
7.	AnginaAND Hypertension/Diabetes on treatment	
8.	CT/MRI documented stroke AND Hypertension/Diabetes on treatment	
9.	Pulmonary artery hypertension AND Hypertension/Diabetes on treatment	
10.	Diabetes (> 10 yearsORwith complications) AND Hypertension on treatment	
11.	Kidney/ Liver/ Hematopoietic stem cell transplant: Recipient/On wait-list	
12.	End Stage Kidney Disease on haemodialysis/ CAPD	
13.	Current prolonged use of oral corticosteroids/ immunosuppressant medications	
14.	Decompensated cirrhosis	
15.	Severe respiratory disease with hospitalizations in last two years/FEV1 <50%	
16.	Lymphoma/ Leukaemia/ Myeloma	
17.	Diagnosis of any solid cancer on or after 1st July 2020 Orcurrently on any cancer therapy	
18.	Sickle Cell Disease/ Bone marrow failure/ Aplastic Anemia/ Thalassemia Major	
19.	Primary Immunodeficiency Diseases/ HIV infection	
20.	Persons with disabilities due to Intellectual disabilities/ Muscular Dystrophy/ Acid attack with involvement of respiratory system/ Persons with disabilities having high support needs/ Multiple disabilities including deaf-blindness	

I am aware that providing false information is an offence.

Name of RMP: __________________

Medical Council registration number of RMP: ____________

Date of issuing the certificate: ____________

Place of issue: __________________.

(Signature of RMP)