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No. NHM/3821/ADMIN1/2020/SPMSU (I)

Dated: 19.05.2021

To

The District Collector, All Districts
The District Medical Officers, All Districts

Sir / Madam,

Sub:- Vaccination of 18-44 age group - Revision of Comorbidity criteria for priority COVID vaccination in 18-44 years group - orders issued reg

Ref:- This office letter No. NHM/3821/ADMIN1/2020/SPMSU dated 16/5/21

As per the guidelines issued for COVID vaccination of 18-44 years group (Ref 1), it was notified that priority vaccination will be given to those beneficiaries with comorbidities and the list of comorbidities and the format of comorbidity certificate was given as Annexure I (A) and 1 (B) in the proceedings.

It may be noted that Government has revised the list of Comorbid conditions for prioritisation of beneficiaries which is more applicable to the State and for ease of comprehension . The revised list of Comorbid Conditions and the revised Comorbidity certificate is attached as Annexure I(A) and I (B) to this letter. The revised list may be used henceforth and wide publicity be given to all concerned. This is for URGENT necessary action and compliance.

Yours faithfully
Dr.Rathan U. Kelkar IAS
State Mission Director

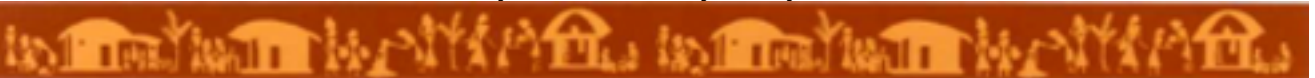
Approval Valid

Digitally Approved By
Dr.Rathan U. Kelkar IAS
Date: 19.05.2021
Reason: Approved

Copy to

District Program Managers, All Districts
District RCH Officers, All Districts

The document is digitally approved. Hence signature is not needed.



**Annexure I (A)List of specified Comorbidities for determination of eligibility of citizens
in age group 18-44 years for priority vaccination**

SN	Criterion
1	Diabetes Mellitus
2	Hypertension
3	All Cardiac Diseases (Congenital/Acute/Chronic)
4	All Lung Diseases including Asthma
5	All Neurological Conditions
6	Developmental Disorders
7	All Renal Diseases
8	All Liver Diseases
9	Inflammatory Bowel Disease
10	Any Cancer or on treatment for cancer
11	All Genetic disorders
12	Congenital Metabolic Disorders
13	Obesity- BMI >30 kg/m ²
14	Endocrine Disorders
15	Rheumatological Disorders
16	Persons on Immunosuppressive therapy
17	Auto Immune Diseases
18	Hematological conditions- Sickle Cell Disease/ Bone marrow failure/ Aplastic Anemia/ Thalassemia Major
19	Primary Immunodeficiency Diseases/ HIV infection
20	Poly Cystic Ovarian Disease (PCOD)
21	Differently abled individuals
22	Any organ transplant -including Hematopoietic stem cell transplant: Recipient/On wait- list/Donor
23	Any other conditions which merits vaccination as per the certifying doctor.

**Annexure I (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.	Diabetes Mellitus	
2.	Hypertension	
3.	All Cardiac Diseases (Congenital/Acute/Chronic)	
4.	All Lung Diseases including Asthma	
5.	All Neurological Conditions	
6.	Developmental Disorders	
7.	All Renal Diseases	
8.	All Liver Diseases	
9.	Inflammatory Bowel Disease	
10.	Any Cancer or on treatment for cancer	
11.	All Genetic disorders	
12.	Congenital Metabolic Disorders	
13.	Obesity- BMI >30 kg/m ²	
14.	Endocrine Disorders	
15.	Rheumatological Disorders	
16.	Persons on Immunosuppressive therapy	
17.	Auto Immune Diseases	
18.	Hematological conditions- Sickle Cell Disease/ Bone marrow failure/ Aplastic Anemia/ Thalassemia Major	
19.	Primary Immunodeficiency Diseases/ HIV infection	
20.	Poly Cystic Ovarian Disease (PCOD)	
21.	Differently abled individuals	
22.	Any organ transplant including Hematopoietic stem cell transplant: Recipient/On wait-list/Donor	
23.	Any other conditions which merits vaccination as per the certifying doctor. Please specify the Condition...	

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)