



Community COVID-19 Vaccine Survey

In anticipation of rolling out COVID-19 vaccination in our community, RCMS is putting together a list of people who are willing to get this vaccine. This list will be broken down by the priority tiers that State and County Public Health requires for vaccine distribution.

Availability of the vaccine, at this time, is totally controlled by the Public Health department. RCMS does not have the ability to directly obtain the vaccines – it must come through Public Health. When and how many vaccines will be provided to RCMS is decided by Public Health.

Having your name in the list helps distribution planning for the vaccine, but does not guarantee getting one. This is a voluntary survey and the information is for RCMS's vaccine distribution plan only.

1. Contact Information
(this question requires an answer)

Name	_____
Company	_____
Physical address	_____
Mailing address	_____
City	_____
State	_____
Zip	_____
Email address (required for contact)	_____
Phone number	_____

2. Date of Birth (mm/dd/yyyy)
(this question requires an answer)

3. Are you an established patient of RCMS?
(this question requires an answer)

- Yes
- No

4. History of Anaphylaxis (a severe allergic reaction that requires to be treated right away)?
(this question requires an answer)

- Yes
- No

5. Profession/Volunteer
(this question requires an answer)

- Medical worker (MD/PA/NP/RN/MA, etc)
 - First responder (EMT/Paramedic, etc)
 - Medical caregiver
 - Teacher
 - Child care provider
 - Firefighter
 - Home health care worker
 - Public health worker
 - Police/law enforcement
 - Jail worker
 - Dental worker
 - Lab worker
 - Pharmacy worker
 - Physical/occupational therapy
 - Grocery store worker
 - Restaurant worker
 - Sewer/waste water/utility worker
 - Retired
 - Other profession (please specify):
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6. Do you live in a nursing home?
(this question requires an answer)

- Yes
- No

7. Are you experiencing homelessness?
(this question requires an answer)

- Yes
- No

8. Do you live in a residential facility?
(this question requires an answer)

- Yes
- No

9. Have you had COVID-19 diagnosed in the past?
(this question requires an answer)

- Yes
- No

10. Do you have any pre-existing conditions?
(this question requires an answer)

- Yes
- No

11. If yes, what is/are your pre-existing condition(s)?

- Asthma/COPD/Chronic lung disease
 - Heart disease
 - Diabetes
 - Immunocompromised
 - Obesity
 - None of the above
 - Other (please specify)
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Please mail your completed survey to:

Dawn McQuarrie
RCMS
PO Box 1100
Gualala CA 95445

Results will be kept confidential. Thank you.