Clinically Responsible for mAB Infusion Attestation Form

To be completed by the clinically responsible person at each site administering mAB infusions on or before the submission of that site's first mAB order

Monoclonal antibodies (mAB) can be administered to a patient via intravenous (IV) infusion in order to treat COVID-19. Monoclonal antibody treatment can only be provided under the order of a physician or licensed practitioner. Given that supply is extremely limited, it is critical for providers to administer mAB in accordance with the criteria and protocol set forth by the FDA and CDC to ensure maximum effectiveness of available infusions. To acknowledge your understanding of these criteria and the proper administration of mAB infusions, please initial by each of the criteria below and sign the bottom of the form in the designated fields.

I understand that to receive a mAB infusion, a patient must have tested positive for COVID-19 within the prior 7 days	Initial:	Date:
I understand that to receive a mAB infusion, a patient must be symptomatic	Initial:	Date:
I understand that to receive a mAB infusion, a patient must be at an increased risk of severe disease	Initial:	Date:
I understand that to receive a mAB infusion, a patient must not yet be sick enough to be hospitalized	Initial:	Date:
I assert that I will administer mAB infusions according to the above criteria as well as any guidelines set forth by the FDA and CDC in order to use these infusions appropriately given their limited supply	Initial:	Date:

Clinically Responsible Signature and Contact Information

Clinically Responsible Person's Signature:	Date:
Clinically Responsible Person's Name:	Title:

Clinically Responsible Person's Organization:

Phone #:	Mobile #:	Fax #:

Email Address:

mAB Distribution Information

Desired date of infusion event:

Will you partner w/Infusion Provider: ☐ Yes ☐ No

Partner name (if applicable):

Please submit this completed form to OEMS@delaware.gov. The remainder of this document is for internal processing.

Remainder of Document Internal Processing

Received by (Printed Name):

Received by (Signature):

Received on (Date):