CITY OF PASSAIC
DIVISON OF HEALTH

PATIENT ATTESTATION FOR NO INSURANCE
PATIENT ATTESTATION FOR NO IDENTIFICATION
COVID-19 VACCINATION

Please print all information clearly

☐ **NO INSURANCE**

I, _____, attest that I am uninsured effective as of _____/_____/_____.

☐ **NO IDENTIFICATION**

I, _____, attest that I am unable to provide identification because_____.

Date of Birth (mm/dd/yyyy): _____/_____/_____

Home Address: _____

Apt. _____

City, State _____

Zip Code _____

Home Number: _____

Cell Number: _____

I affirm that all information given on this attestation is true, complete, and accurate to the best of my knowledge.

Signed (patient): _____ Date: _____/_____/_____

Witnessed: _____ Date: _____/_____/____