CARE ID
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Pfizer COVID-19 Vaccine Study
Participant Enrollment Application

Please complete this application once you have read the study's "General Eligibility Criteria" for participation and the "Informed Consent" disclosure and agree to enroll in the study.

Email Completed Enrollment Application to: info@careidresearch.com

Date:			
First Name:			**Middle Initial:**
Last Name:			**DOB:** (DD/MM/YYYY) / /
Race: (Required) ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **White**			**Ethnicity:** ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino.**
Language Preference:	☐ **English**	☐ **Spanish**	☐ **Other:***(specify)*
Home Address: Street/Unit#_____ City_____ ST_____ Zip Code_____			
Cell Phone:	**Home Phone:**		**Work Phone:**
E-Mail:	**Preferred Method of Contact:** ☐ Phone – home ☐ Phone – mobile		☐ Phone - work ☐ Email
Name of Physician you would like us to communicate with (or n/a):	**Phone Number:** **Fax Number:**		

Emergency Contact Name: **Relationship:** **Phone:**