COVID-19 SELF DECLARATION TOOL V 1.9

Name (please print): **First:** _____ **Last:** _____ **DOB:** _____

Place of residence: **City:** _____ **State:** _____

Employer (please print): _____ **Job Site:** _____

1. **Are you currently experiencing any flu or COVID-19 like symptoms i.e. having or feeling Feverish (>99.4˚), Cough, Shortness of Breath, Diarrhea, Nausea, Metallic Taste or Loss of Taste or Smell?** ☐ YES ☐ NO

2. **Do you currently, or have you recently; lived with, cared for, shared same indoor environment with or been intimate with an individual:**

   a. *48 hours before they showed any of the above symptoms?* ☐ YES ☐ NO
   b. *Currently having any of the above symptoms?* ☐ YES ☐ NO
   a. *Suspected to have, or has been tested for, COVID-19?* ☐ YES ☐ NO

   If you answered "Yes" to any of the above, how long? _____

3. **Within the last 14 days, have you been within 6 feet of an individual, for 15 minutes or longer, suspected of having or diagnosed with, COVID-19?** ☐ YES ☐ NO

4. **Within the last 21 days, have you utilized public transportation services such as Airplanes, Buses or Subway Systems?** ☐ YES ☐ NO

5. **Have you ever had a positive COVID 19 test?** ☐ YES ☐ NO

   If "Yes" describe type and date of test and return to work instructions:

As of today, and to the best of my knowledge, I verify the above information is accurate.

Signature: _____

Administrator: _____ **Temp:** _____

Physician Notified: _____ **Date:** _____

Ag/Ab Results: _____ **PCR:** _____

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