COVID-19 Questionnaire for Examining Physicians to Complete in Company-Managed Clinics Each Day Performing Examinations

Please respond by checking any box applicable to you and sign below, and provide the completed copy to the front desk staff.

1. If you have tested positive for COVID-19 please indicate which of the following statements are true, if any:

☐ **If you were symptomatic** (had symptoms), you have been in isolation for at least 14-days since symptoms first began, and you have not had symptoms in the past 3 days.

☐ **If you were asymptomatic** (did not have symptoms), you have been in isolation for at least 14-days beginning from the date you were tested and you have not experienced any symptoms during this 14-day period.

☐ **You have NOT completed a 14-day quarantine.** If you check this box, please note the date you were diagnosed with COVID-19 and the date you first became symptomatic (if applicable).

Date first symptomatic: ____/_____/_____ Date diagnosed with COVID-19: _____/_____/_____

2. If you have not tested positive for COVID-19, please select any of the following that apply:

☐ **Have you travelled** internationally in the past 14 days? If so, please note the date of your return and the area(s) you visited.

Date of return from international travel: _____/_____/_____ Areas visited: _____

☐ **Have you had close contact (defined as within closer than 6 feet for 10 minutes or more) with someone** who was diagnosed with or suspected to have COVID-19 within the past 14 days? (For example, a family member you live with or a co-worker). If so, please note the last date you had contact with this person and whether the person was actually diagnosed.

Date of last contact with person: _____/_____/_____ Person actually diagnosed: Yes / No

☐ **Have you been mandated to go into quarantine** by your physician or a department of health within the past 14 days? If so, please explain the date the quarantine began and the reason for quarantine.

Date quarantine began: _____/_____/_____ Reason for quarantine: _____

☐ **Have you had fever, chills, cough, shortness of breath, sore throat, or any other flu-like symptoms** within the past 14 days? If so, please note the date you first became symptomatic (had symptoms) and the last date you were symptomatic.

Date first became symptomatic: _____/_____/_____ Date last symptomatic: _____/_____/_____

Name (printed): _____ Signature: _____ Date: _____ / _____/ _____

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