**Coronavirus Self Declaration Form**

**Entry to \*ADDRESS\***

**COMPANY NAME**

For the health and safety of our community, declaration of illness is required. Be sure that the information you'll give is accurate and complete. Please get immediate medical attention if you have any of the COVID-19 signs or symptoms.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_ \*Date: \_\_­\_\_\_\_\_\_\_

Company: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you traveled abroad in 2020? Yes: \_\_­­­­\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_

Name of the area(s) visited & dates of travel:

Have you traveled to any state requiring quarantine upon return? Yes: \_\_­­­­\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_

State(s) visited & dates of travel:

Have you tested positive for COVID-19 within the past 14 days? Yes: \_\_­­­­\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_

Have you been in close or proximate contact with anyone infected, Yes: \_\_­­­­\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_

suspected of or diagnosed with COVID-19 within the last 30 days?

If YES, please indicate your relationship with them and your last contact date with them:

Please state whether you've experienced/are experiencing the following in the past 14 days:

 Fever: Yes: \_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cough Yes: \_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Shortness of Breath: Yes: \_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persistent Pain in the Chest: Yes: \_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Loss of Smell or Taste: Yes: \_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you checked “YES”, please indicate the date(s) you experienced the symptom:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

By signing below, I acknowledge that the information I've given is accurate and complete.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_

*\*Form to be filled out and saved each day spent working on premises.*