

Office Guest Covid Screening Questionnaire

Please complete this questionnaire before entering the office premises. This document is for health and safety screening purposes and can be printed for record-keeping.

Guest Information

Full Name:

Phone Number:

Email Address:

Date of Visit:

Name of Host / Person Being Visited:

Health Screening Questions

Please type "Yes" or "No" in the boxes below for each question.

1. Are you currently experiencing any symptoms of COVID-19 (such as fever, cough, shortness of breath, sore throat, or loss of taste/smell)?

Answer (Yes/No):

2. Have you tested positive for COVID-19 in the past 10 days?

Answer (Yes/No):

3. Have you been in close contact with anyone who has tested positive for COVID-19 or shown symptoms in the past 14 days?

Answer (Yes/No):

4. Are you currently under any self-quarantine or isolation orders?

Answer (Yes/No):

Declaration

By signing below, I certify that my answers are true and correct to the best of my knowledge.

Guest Signature (Type Name to Sign):

Date Signed: