

COVID-19 Screening Declaration

For Retail Customers

Full Name

Contact Number

Date of Visit

Are you experiencing any of the following symptoms: fever, cough, sore throat, shortness of breath, loss of taste or smell?

Have you been in close contact with a confirmed COVID-19 case in the last 14 days?

Have you returned from international travel in the past 14 days?

Do you have a current requirement to self-isolate as directed by health authorities?

I declare that the above information is true and correct to the best of my knowledge.

Signature

Date