Delivery Driver COVID-19 Access Screening Form

Driver Name

Delivery Company

Phone Number

Date

Time of Arrival

COVID-19 Screening Questions

1. Are you currently experiencing any COVID-19 symptoms (e.g., fever, cough, difficulty breathing, loss of taste or smell)?

Yes No

2. Have you tested positive for COVID-19 in the past 14 days?

Yes No

3. In the past 14 days, have you been in close contact with anyone confirmed or suspected to have COVID-19?

Yes No

4. Have you traveled outside the country or been instructed to quarantine in the past 14 days?

Yes No

Signature

_____

Name / Signature