Contractor COVID-19 Health Declaration

Name

Company

Contact Number

Date

Health Screening

Are you currently experiencing any of the following symptoms? (Fever, cough, sore throat, shortness of breath, loss of taste/smell)

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

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

Declaration

☐ I declare the information provided is true to the best of my knowledge.

Signature