Employee COVID-19 Daily Health Declaration

Full Name

Employee ID

Department

Date

Health Screening Questions

1. Do you have a fever or chills?
Yes

No

2. Do you have a cough or sore throat?
Yes

No

3. Have you experienced difficulty breathing?
Yes

No

4. Have you had contact with a confirmed COVID-19 case in the past 14 days?
Yes

No

I declare that the above information is accurate and complete to the best of my knowledge.