COVID-19 VISITOR FORM

THIS FORM MUST BE COMPLETED ON THE DATE OF THE VISIT

Print Name: _____Company: _____

1. Are you experiencing or have experienced in the last 10 days Covid-19 symptoms (fever≥ 100.4 °F; difficulty breathing; loss of taste/smell; fatigue/muscle or body ache; new onset cough; nausea/vomiting/diarrhea; sore throat; headache, congestion/runny nose)?

   Yes ☐ No ☐

2. Have you recently been in contact with anyone who tested positive for the Covid-19 or who exhibits Covid-19 symptoms?

   Yes ☐ No ☐

3. It is your responsibility to inform OCWD (or MWDOC) if you test positive for Covid-19 or experience ANY COVID-19 like symptoms.

Signature:_____ Date: _____