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$\geq$ 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. Do you know that it's your responsibility to inform OCWD if you test positive for Covid-19 or experience any symptoms? Yes ☐ No ☐

4. By signing this form, you are acknowledging that you understand that all visitors/contractors/vendors to OCWD are required to wear a face covering indoors if they are unvaccinated.

Signature: ___________________________________ Date: _________________________