COVID-19 SCREENING VISITOR ATTESTATION FORM

I do hereby swear that the following statements are true of myself, _____

(Please print name)

who is visiting WAJ. I understand that providing false statements may have severe consequences and may place others at risk for COVID-19.

REASON or DESTINATION of VISIT:	**Time In:**	**Time Out:**
In the past two weeks (14 days) have you experienced any symptoms of COVID19 such as a temperature of greater than 100.0°F, cough, shortness of breath or difficulty breathing, extreme tiredness (fatigue), muscle or body aches, headache, loss of taste or smell, sore throat, stuffy or runny nose, nausea or vomiting, and/or diarrhea?	☐ Yes	☐ No
Have you traveled internationally or from a state with a widespread community transmission of COVID-19 per the New York State Travel Advisory in the past 14 days?	☐ Yes	☐ No
Have you knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive through a diagnostic test for COVID19 or who has or had symptoms of COVID19?	☐ Yes	☐ No
Have you tested positive through a diagnostic test for COVID19 in the past 14 days?	☐ Yes	☐ No

SIGNATURE		Date:
CONTACT INFORMATION:	Email address:	Phone #:

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