Name _____

Phone number _____
Including Area Code

Last 4 of SSN _____

Please check all that apply.

- [ ] **1. Do you have a fever, cough or shortness of breath, or flu-like symptoms?**

- [ ] **2. In the past 14 days, have you, or a close contact, traveled to an area with ongoing spread of COVID-19 (coronavirus)?**

- [ ] **3. Have you been in close contact with anyone who tested positive for COVID-19?**

- [ ] **4. NONE OF THE ABOVE**