

## **COVID-19 QUESTIONNAIRE**

*The following simple screening questionnaire is in place to prevent the spread of COVID-19 and reduce the potential risk of exposure to our team. We appreciate your participation to help us take precautionary measures to protect you and everyone throughout our production.*

*Please complete the attached questionnaire for EACH person.*

*If the answer is "yes" to any of the questions, access to the production set will be denied.*

Name: \_\_\_\_\_

Company/Role: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Have you travelled outside of the country within the last 14 days?

Yes

No

Have you had close contact with or have cared for someone diagnosed with COVID-19 within the last 14 days?

Yes

No

Have you been in close contact with anyone who has traveled outside of the country within the last 14 days?

Yes

No

Have you experienced any cold or flu-like symptoms in the last 14 days (including fever, cough, sore throat, respiratory illness, difficulty breathing, nausea, vomiting)?

Yes

No

Signature: \_\_\_\_\_

Date: \_\_\_\_\_