



## Visitor Self-Assessment Questionnaire

To minimize the potential exposure of our employees and visitors to COVID-19, please complete the following Self-Assessment Questionnaire. Your participation is vital in helping us protect you and everyone within our facility.

Visitor Name:		Visitor Contact Number:	
Visitor Company:		Person or Department Visiting:	
1)	Have you returned from any of the countries below within the last 14 days? <ul style="list-style-type: none"><li>• China</li><li>• Japan</li><li>• All of Europe</li><li>• Iran</li><li>• South Korea</li><li>• Travel via cruise ship, regardless of destination</li></ul> <input type="checkbox"/> Yes <input type="checkbox"/> No		
2)	Have you had close contact with, or cared for, anyone who has returned from any of the countries in the previous question within the last 14 days?  <input type="checkbox"/> Yes <input type="checkbox"/> No		
3)	Have you had close contact with, or cared for, anyone diagnosed with COVID-19 or experiencing flu-like symptoms such as fever, cough, sore throat, respiratory illness, or difficulty breathing within the last 14 days?  <input type="checkbox"/> Yes <input type="checkbox"/> No		
4)	Have you experienced cold or flu-like symptoms such as fever, cough, sore throat, respiratory illness, or difficulty breathing within the last 14 days?  <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

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

Note: If you will be onsite for consecutive days, please immediately notify **Company Name** \_\_\_\_\_ at **Contact Information** \_\_\_\_\_ if any of your responses change. The information on this form will be used to determine your access to our facilities.

# Health Visitor Assessment Examples Numeracy Papers

**Mark Steyvers**



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