

COVID-19 NOVEL CORONAVIRUS

Please complete the following questions before beginning your work today.

Name: _____

Date: _____ Time: _____

Do you have any of the following?



Fever



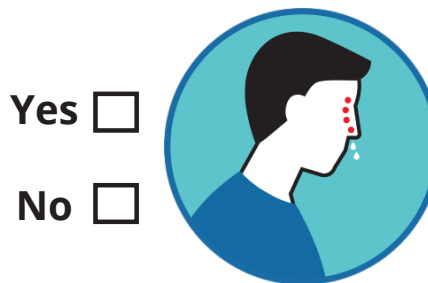
Cough



Shortness of Breath



Sore Throat



Runny Nose



Feeling Unwell

Yes Have you been in close contact with someone who is
No sick or has confirmed COVID-19 in the past 14 days?

Yes Have you returned from travel outside Canada in the
No past 14 days?

If you answered YES to any of these questions, go home & self-isolate right away. Call Telehealth or your health care provider.