**Visitor Screening Questionnaire** **PAM OH Solutions**

Name: \_\_\_\_\_\_\_\_\_ Organisation: \_\_\_\_\_\_\_\_ Host Name: \_\_\_\_\_ \_

If the answer to any of these questions is yes; then you should not proceed with the scheduled appointment;

1. Have you come in close contact with anyone who has self-isolated due to possible COVID-19 in the last 14 days without using appropriate PPE? Yes / No

2. Have you, in the last 14 days, come into contact with someone who is known to have the COVID-19? Yes / No

3. Do you have a fever (even mild), new persistent cough or altered taste/smell? Yes / No

Signature of Visitor: \_\_\_\_\_\_\_\_\_\_\_ \_ Date: \_\_\_\_\_\_\_\_\_\_ \_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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