

# COVID-19 NOVEL CORONAVIRUS

Please complete the following questions before beginning your work today.

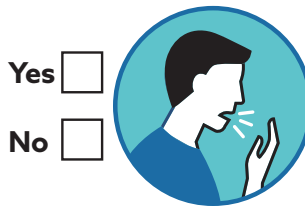
Name: \_\_\_\_\_

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

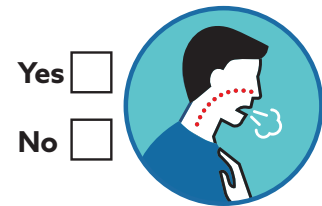
## Do you have any of the following:



**Fever**



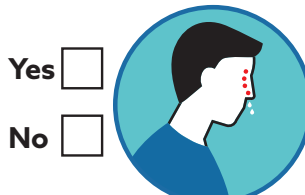
**Cough**



**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.**