Hospice Self-Assessment & Contact Form

Member Name:_____ Phone #:_____

Address:_____

Guest #1 name:_____ Phone #:_____

Address:_____

Guest #2 name:_____Phone #:_____

Address:_____

Guest #3 name:_____ Phone #:_____

Address:_____

Guest #4 name:_____ Phone #:_____

Address:_____

Please answer YES or NO in the appropriate box	Member	Guest1	Guest2	Guest3	Guest4
Have you experienced any of these Covid 19 symptoms in the last 14 days? Cough, shortness of breath, headache, runny nose, fever, sore throat, diarrhea, loss of taste or smell.					
Have you traveled internationally, including the U.S.A.(non-essential), within the last 14 days					
Have you been in close contact with a person who has a confirmed or suspected case of Covid 19 within the last 14 days?					

If you have more guests than four, please submit a second form as well.

For the purpose of keeping myself, my guests, and fellow participants safe, I confirm that the responses on this form are accurate.

Members signature:_____Date: _____