WVBBC COVID-19 SCREENING

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: • Fever or chills • Cough • Shortness of breath or difficulty breathing • Fatigue • Muscle or body aches • Headache • New loss of taste or smell • Sore throat • Congestion or runny nose • Nausea or vomiting • diarrhea	**YES**	**NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
Are you currently waiting on the result of a COVID-19 test?	**YES**	**NO**

Did you answer **NO** to **ALL QUESTIONS**?	Please sign and date where indicated below and submit along with your application.
Did you answer **YES** to **ANY QUESTION**?	You must submit a completed Certificate of Health Form along with your application. Form available at *https://wvbbc.com/Portals/WVBBC/docs/CERTIFICATE%20OF%20HEALTH.pdf*

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Applicant's Name Applicant's Signature

_____

Date