# Health-Screening Form

Dear Sir / Madam,

To prevent the spread of COVID-19 in our community and reduce the risk of exposure to any person, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in this building. Thank you for your time.

| | |
|---|---|
| Name: | Personal contact number<br>(Mobile number/Home): |
| NRIC / Passport no*: | Nationality: |
| Organization (If applicable): | |
| Meeting venue/level/department to visit: | Name of host: |
| Temperature reading: | Recorded by staff (name): |

| NO | SELF-DECLARATION |
|---|---|
| 1 | No symptom<br>If you have the following symptom(s), please circle your answer<br>□ Fever □ Cough □ Sore Throat □ Difficulty in breathing<br>Others _____ |
| 2 | Have you been in contact with any Covid-19 cluster declared by MOH or Person Under Investigation (PUI) or a confirmed Covid-19 patient in the past 14 days?<br>□ Yes □ No |
| 3 | Have you been affected COVID-19 countries or area(s) in the past 14 days?<br>□ Yes □ No<br><br>If yes, please indicate the affected country(s) or area (s):_____ |

Signature: _____ Date: _____

*Note: Information captured is used for contact tracing if required