**COVID-19 Self Screening**

**Attestation Form**

By signing this form, I acknowledge that I understand that I have a **continuing** obligation to self-screen on a daily basis and to self-quarantine if any of my answers to the screening questions listed below are “YES” I will not enter a Mountain Health Network facility until I have been medically cleared. I further acknowledge that this is for my health and safety as well as the health and safety of patients and staff.

Do you have any of the following symptoms:

* + Fever?
	+ NEW cough?
	+ NEW shortness of breath?
	+ NEW body aches?
	+ NEW sore throat?
* Are you currently in quarantine or have a test pending for COVID-19?
* Have you had any close contact outside of work with:
	+ A COVID-19+ person?
	+ Person in quarantine or awaiting COVID-19 results?
* Any travel: Internationally or cruise in last 14 days?

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

Printed Name Date

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

Signature