Workplace Safety & Prevention Services®

Pre-Screening / Screening Questionnaire

Visitor Name and Organization:		DATE
Contact Number:		Email:

1. Are you experiencing any of the following symptoms:	YES	NO
a. Fever of 38 C or higher		
b. Cough		
c. Difficulty Breathing or Shortness of Breath		
d. Malaise (severe fatigue or feeling of being generally unwell)		
2. In the last 14 days have you: **a.** Travelled to/from or through	YES	NO
• China • Singapore • Hong Kong • South Korea • Iran • France • Italy • Spain • Japan • Germany		
b. Been in close contact with someone who has a confirmed or probable case of COVID-19		
c. Been in close contact with a person with an acute respiratory illness who has been to the above countries within 14 days prior to their illness onset?		

Signature:	Name (please print):

If you have answered Yes to any of the above questions, please delay your attendance AND contact your healthcare provider, or Telehealth Ontario (1-866-797-0000)

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