

DECLARATION FORM

Dear Sir / Madam

To prevent the spread of **covid-19** in our community and reduce the risk of exposure to our staff and visitors, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in CREATE Campus.

| | |
|-------------------------------------|---------------------------|
| Name: | Contact Number: |
| NRIC/WP (Last 3 digits & Alphabet): | Company/Entity: |
| Location & Purpose of visit: | |
| Temperature reading of visitor: | Recorded by staff (name): |

| Self-declaration by visitor | |
|-----------------------------|--|
| 1 | <p>If you have the following symptom(s), please tick the relevant box(es)</p> <p><input type="checkbox"/> Fever <input type="checkbox"/> Dry cough <input type="checkbox"/> Body aches <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose <input type="checkbox"/> Tiredness <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> None <input type="checkbox"/> Others:</p> |
| 2 | <p>Have you been in contact with a confirmed case in the past 14 days?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| 3 | <p>Have you been to overseas in the past 14 days?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please indicate the country(s):</p> |

Signature (visitor):

Date & Time: