[COMPANY NAME]
LICENSEE/EMPLOYEE QUESTIONNAIRE

Licensee/Employee Name: _____

1. Do you currently have symptoms such as fever, chills, sweats or a temperature that is elevated for you or is 100°F or greater?
2. Do you currently have symptoms such as cough, shortness of breath, chest tightness, vomiting, nausea or sore throat?
3. In the past 14 days, have you had close contact with an individual diagnosed with COVID-19?
4. In the past 14 days, have you traveled on an airplane internationally or domestically?

If the answer to ANY of these questions is "yes," then for the safety of others, you must leave the office immediately.

Date	Signature