



COVID-19 Self-Assessment Questionnaire

The safety of our participants, visitors and staff is of the utmost importance to us. We ask that daily, all review the items below. Please stay at home and consider seeking medical advice should you have any affirmative responses to this questionnaire.

Do you have, or have you recently had, any of the following?

	Yes	No
Fever		
Coughing		
Shortness of breath or difficulty breathing		
Chills or repeated shaking with chills		
Muscle pain		
Headache		
Sore throat		
New loss of taste or smell		
Exposure to anyone known, or suspected to have, COVID- 19?		

General Guidance for all Training Sessions:

- Please maintain social distancing
- Exercise personal hygiene including hand washing, hand sanitizer
- Wear mask/face-covering at all times
- Please notify staff at 800-875-4770 should you experience symptoms; been exposed; or have been diagnosed with COVID-19.

I certify that the information I have provided above is true and accurate and I will follow all the *General Guidance for all Training Sessions* as listed above.

Print Name
Signature
Date

Please provide the following contact information while attending training session:

- Email Address:
- Mobile Phone:
- Company Phone: