ROCKROSE

Name:_____ Date of visit: _____

Your Company Name: _____ Your Phone Number:_____

Purpose of visit and name of company you will visit: _____

_____

PLEASE ANSWER HONESTLY:

1. Have you had close contact in the last 14 days with a lab-confirmed COVID-19 patient? YES NO

2. Are you currently or have you had any of these symptoms in the last 14 days?

- Cough
- Shortness of breath or difficulty breathing
- Fever greater than 100

Or at least two of these symptoms:

Chills	Headache
Repeated shaking with chills	Muscle pain
Sore throat	New loss of taste or smell

YES NO

3. Have you been tested for COVID-19 and are awaiting the results? YES NO

If you answered YES to any of the above, please reschedule your visit when you are well. Thank you for helping us keep our tenants and staff healthy and safe.

I do not have any of the above symptoms.

Signature: _____

Date: _____