



SALEM ASSEMBLY OF GOD COVID -19 SCREENING QUESTIONS

1. In the last 14 days, did you receive a confirmed diagnosis of COVID-19 by a healthcare professional or are you waiting for a pending COVID-19 test result?

Yes No

2. In the last 14 days, have you had close contact with or cared for someone currently diagnosed with COVID-19?

Yes No

3. In the last 14 days, have you experienced any flu-like symptoms including (but not limited to) fever, cough, shortness of breath, sore throat, chills, loss of smell or taste? (NOTE: "Yes" if worse than what you normally experience, "No" if common issue cleared by health professional)

Yes No

4. In the last 14 days, have you traveled domestically or internationally (except commuting between work/home by personal vehicle)?

Yes No

a. If yes to question 4, where and how (ex. plane, bus, ferry)

I certify the above information is true and release Salem Assembly of God from any and all liability for unintentional exposure or harm due to COVID-19

X _____
(sign name)

(print name)

(date)