**Self Service User COVID-9 Questionnaire**

Please email a copy with your responses back to us.

**Self Service User Name:**

**Self-Service Date:**

a) Do you have any of the following: fever or chills, cough, shortness of breath or difficulty breathing, body aches, headache, new loss of taste or smell, sore throat?

b) Have you traveled out of state the last 14 days?

c) Have you come into close contact (within 6 feet) with someone who has a laboratory confirmed COVID – 19 diagnosis in the past 14 days?

d) Have you recently been tested for COVID and have results that are pending?