

MEMBER SERVICES PRESCREENING: VISITOR FORM

for COVID-19 contact tracing purposes

Please complete the following prescreening form and return your form to the CTPF receptionist.

SECTION 1: MEMBER/VISITOR INFORMATION

Legal Name: First	Last	Last 4 digits of SSN or Member ID:
Primary Phone:	Email:	

CTPF COVID-19 HEALTH SCREENING STATEMENT

All visitors **MUST** be up-to-date on their COVID-19 vaccination and provide proof of their COVID-19 vaccination upon entry.

By entering any of our sites, you confirm that you meet the following requirements and have not been experiencing these symptoms prior to entry:

- I am NOT currently experiencing COVID-19 related symptoms, irrespective of my vaccination status.
- I have NOT experienced COVID-19 related symptoms in the last 10 days, irrespective of my vaccination status.
- I am NOT awaiting the results of a viral test to COVID-19 infection.
- I have NOT had prolonged close contact with any person with confirmed, suspected, or possible COVID-19 in the last 10 days. The following are exempted from this requirement:
 - Asymptomatic (*showing no symptoms*) people who have tested positive for COVID-19 within the last three months, have recovered, and been cleared to be around others.
 - Asymptomatic (*showing no symptoms*) people who are up to date with COVID-19 vaccinations authorized/approved by the U.S. Food and Drug Administration or World Health Organization.
- If I have been ordered to quarantine (*i.e., based on close exposure or travel*) or isolate (*i.e., based on COVID-19 diagnosis*), I have been successfully cleared to be around others.

Examples of COVID-19 Symptoms:

Fever or feeling feverish (chills, sweating, temperature $\geq 100^{\circ}\text{F}$)

New cough

Difficulty breathing

Sore throat

Muscle aches or body aches

Vomiting or diarrhea

New loss of taste or smell

Subsequent Diagnosis:

If you test positive for COVID-19 within 48 hours of this appointment, by signing this form I agree to contact CTPF so that contact tracing, if necessary, can be conducted.

SECTION 2: CONFIRMATION

Signature:	Date:
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CTPF USE ONLY

For Office Use: Proof of Vaccination Provided? Yes No | **Verified by:** _____