

COVID-19 Health Screening Questionnaire

Failure to truthfully comp	lete this questionnaire shall be considered a breach of Rule 1001.
Name:	
Signature:	
Employer:	
Role:	
Date:	// 2020
1. Have you had close cor	stact with a confirmed or probable case of COVID-19?
YES NO] (tick one)
If you answered yes, pleas	se provide details including date and person you have been in contact with
2. Have you returned fror	n overseas travel in the last 14 days?
YES NO] (tick one)
If you answered yes, pleas	se provide details of your overseas travel and the date you returned to NZ.
3. Do you think you may h	nave a fever?
YES NO	(tick one)
4. Do you have a cough, s	ore throat or shortness of breath?
YES NO	(tick one)
5. Have you experienced	a loss of or change in your sense of smell?
YES NO] (tick one)

If any of the above questions is answered "YES" the Employer must:

- Instruct that the Staff member, and any persons who have been in close contact within the
 past 48 hours, that they are immediately stood down and instructed to adhere to strict
 self-isolation.
- Advise the operator of the training venue.
- Advise HRNZ (lbishop@hrnz.co.nz)