COVID-19 Health Screening Questionnaire

Failure to truthfully complete this questionnaire shall be considered a breach of Rule 1001.

Name: _____

Signature: _____

Employer: _____

Role: _____

Date: _____ / _____ / 2020 **Mobile Phone Number:** _____

1. Have you had close contact with a confirmed or probable case of COVID-19?

YES ☐ **NO** ☐ ***(tick one)***

If you answered yes, please provide details including date and person you have been in contact with

_____

2. Have you returned from overseas travel in the last 14 days?

YES ☐ **NO** ☐ ***(tick one)***

If you answered yes, please provide details of your overseas travel and the date you returned to NZ.

_____

3. Do you think you may have a fever?

YES ☐ **NO** ☐ ***(tick one)***

4. Do you have a cough, sore 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)**