COVID-19 SCREENING REGISTER (EMPLOYEES/VISITORS)

Date: _____ **Location:** _____

Surname	Full Names	ID/Passport No	Cell No.	Symptoms Declared	Signature	Temp Reading	Symptoms Noticed

NOTE: Every person is obligated to disclose symptoms associated with COVID-19. By signing this document, you acknowledge that the information provided is true, and consent that your personal details may be provided to the DoH and/or relevant Institution, as detailed in Section 8 of Government Gazette No. 43258 of 29 April 2020, for the purposes of contact tracing relating to COVID-19.