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SafetyCulture



Title Page

Case ID

Name

Location

Date

Form Accomplished By

Case Information

Personal Details

First Name

Surname

Age

Contact number

Alternative contact number

Email

Address



Symptoms

Symptom Onset



Please select all symptoms you are currently experiencing

Cough

☐

Fever

☐

Sore throat

☐

Shortness of breath

☐

Runny nose

☐

Fatigue

☐

Loss of smell/or taste

☐

Other symptoms

☐

No symptoms

☐

Location/s visited (if applicable)

Location



Date Visited



Time Arrived



Time Departed



Close Contacts Information

Name

Age

Relation to Case

Last Contact with Case



Address



Contact Number



Emergency Contact Information

Full Name

Relationship

Contact number

Alternative contact number

Email

Address



Final Remarks

Comments

Person Under Investigation



Assigned Contact Tracer



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