Diagnosis Form

For the health and safety of our community, declaration of illness is required. Be sure that the information you'll give is accurate and complete. Please get immediate medical attention if you have any of the COVID-19 signs.

Name

First Name Last Name

ID Number

Department

Diagnosis

Country, State, City

Treatment

Referral

Please state whether you've experienced/are experiencing the following

	Yes	No
Fever	○	○
Cough	○	○
Shortness of Breath	○	○
Persistent Pain in the Chest	○	○

I acknowledge that the information I've given is accurate and complete.

Date

Month Day Year