Falck
Global Assistance

Health Declaration- Medical Screening (COVID -19)

Name		DOB	
Mobile no.		Blood Group	
Address		Email	

sn	Please Answer the following: Do you have,	Yes/No	Specify
1	Any history of Fever since last two weeks		
2	Any history of Cough and Cold since last two weeks		
3	Any history of Difficulty in Breathing		
4	Any H/O travel in restricted countries in last 14 days		
5	Your location of Work/Stay since last 14 days:		
6	Any history of contact with Corona virus (COVID-19) patient		
7	Have you been ever Quarantine or asked to quarantine by the Government?		
8	Has any of your family member been quarantine or treated or is undergoing any treatment regarding COVID-19		
9	Any h/o Diabetes, Hypertension, Heart Disease		
10	Are you on any medications? If yes provide the details		
11	Are you suffering from any serious/contagious ailment and/or any psychiatric /psychological disorder?		
12	Any history of medical, required admitting hospital for treatment? (If yes, please specify/share reports)		
13	Any history of undergone surgery? (If yes, please specify/share reports)		
14	Any history of back related problem or issue? (If yes, please specify/share reports, with current status)		
15	Are you having any Vision difficulties/disabilities? (if yes please, specify)		
16	Are you having any Hearing difficulties/disabilities? (if yes, please specify)		
17	Are you having any other noticeable disabilities? (If yes, please specify)		

Self-Declaration by the employee: I hereby declare that the information furnished above by me is true to the best of my knowledge. I do hereby declare that above particulars of information and facts stated are true, correct and complete to the best of my knowledge and belief and I will be completely responsible for any action if the information provided by me is false or untrue.

Also, If I have any of the symptoms as mentioned in my questionnaire during my temporary fitness to work from home, I will report this matter immediately to my concerned authority.

Signature: Date: