|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **In view of the COVID-19 epidemic, we request all employees /Visitors to fill-out the self-declaration form below. This is a preventive measure for avoiding any infection outbreak in our office.**  **This information will be stored confidentially and is not shared with any third party unless there will be an official request by the local authorities for reasons of public health.**  **Thank you for cooperation.** | | | | | | | | | |
| 1 | Full Name | | |  | | | | | |
| 2 | Age in years | | |  | | | | | |
| 3 | Employee ID | | |  | | | | | |
| 4 | Contact Number | | |  | | | | | |
| 5 | Where did you stay during the lock down period (Detailed Address &Pin Code)? | | |  | | | | | |
| 6 | Which is your current address?  What is current status of this zone (Red/Amber/Green)? | | |  | | | | | |
| 7 | Have you completed self-isolation or quarantine period as prescribed by Government Officials after travel? | | |  | | | | | |
| 8 | Please list the country /cities you have travelled in the last 14 days & mode of travel used: | | |  | | | | | |
| 9 | Have you been in contact with people travelled from abroad or undergoing quarantine/isolation in last 14 days? a. Do you find any of flu like symptoms with them?  b. If yes, specify details | | |  | | | | | |
| 10 | Have you been in contact with people being infected, suspected or diagnosed with COVID19?  If yes, provide details. | | |  | | | | | |
| 11 | Please State if any of below mentioned members have experienced / experiencing any of the following flu-like symptoms (Yes/No for each row): | | | | | | | | |
| **No** | **Symptoms** | **Self** | **Spouse** | **Child1** | **Child2** | **Father** | **Mother** | **Siblings** | **Room Partners** |
| a | Fever >99F |  |  |  |  |  |  |  |  |
| b | Cold/Cough/Sneezing |  |  |  |  |  |  |  |  |
| c | Difficulty in breathing |  |  |  |  |  |  |  |  |
| d | Sore Throat |  |  |  |  |  |  |  |  |
| e | Any other prevailing illness such as diabetes / Hypertension / asthma or any other respiratory issues or undergoing prolonged treatment |  |  |  |  |  |  |  |  |
| f | Any Member dealing with COVID19 patients as Medical staff member (Doctor/Nurse/any other service at hospitals) |  |  |  |  |  |  |  |  |
| **I acknowledge that the information given above is accurate and complete.**  **I have willingly come to work location and shall adhere to all preventive measures and instructions, as laid down by the organization and Government of India.**  **I shall inform Reporting Manager/HR in case of any change in the details mentioned above while working at office premise.** | | | | | | | | | |
| **Signature** | |  | | | | | | | |
| **Location** | |  | | | | | | | |
| **Date & Time** | |  | | | | | | | |