COVID 19 MEMBER SCREENING AND WAIVER

Full Name

Email Address

Gender

Street Address

City

Province/Region

Zipcode

Country

Date of Birth

Covid-19 Client Screening.

[redacted]

[redacted]

- Fever over 100.4

  Initial here:

- Shortness of breath

  Initial here:

- Coughing

  Initial here:

- Loss of smell

  Initial here:

- Loss of taste

  Initial here:

[redacted]

Initial here:

[redacted]

Initial here:

[redacted]

[redacted]

Initial here:

[redacted]

Initial here:

[redacted]

Initial here:

[redacted]ill [redacted]

Initial here:

I agree to these terms.

Sign your name below:

Please read the Electronic Records and Signature Disclosure

I agree to use electronic records and signatures