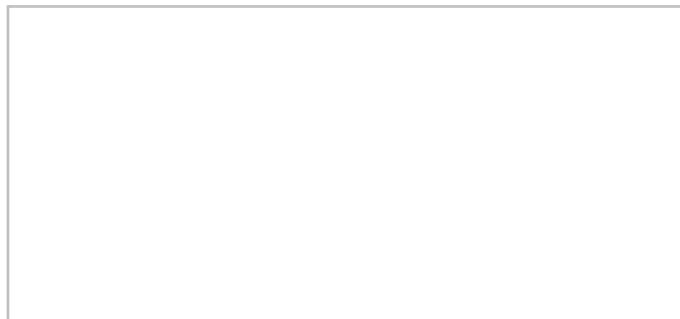




COVID-19 SCREENING DECLARATION FOR INDIVIDUALS

Date:

I, the undersigned, hereby confirm that:

1. I have familiarised myself with the provisions of the organisation's workplace plan, policies and procedures regarding COVID-19.
2. I have not experienced any of the following symptoms in the past 14 days:
 - Fever in excess of 37.3 degrees
 - Cough
 - Sore throat
 - Redness of eyes
 - Shortness of breath (or difficulty in breathing).
3. I do not suffer from any of the following additional symptoms:
 - Body aches
 - Loss of smell or loss of taste
 - Nausea
 - Vomiting
 - Diarrhoea
 - Unusual fatigue
 - Weakness or tiredness.
4. I have not been in contact with other persons, that I am aware of, that suffered/suffer from the symptoms noted in paragraphs 2 and 3 above.
5. I undertake to immediately inform the Employer if I or any of my co-workers experience any of the symptoms in sub-clauses 2 and 3 while at work.

Full Names	Surname	ID number	Cell number

Date	Signature	Temp.	Time in	Time out