

COVID QUESTIONNAIRE

1. Did you travel or plan to travel to a strongly COVID-19 affected area, region or country?

Yes ☐

No ☒

If yes, please advise in detail about travel locations and exact durations of stay(s)

2. Within the last 14 days did you have close contact with a confirmed or suspected COVID-19 infected person?

Yes ☐

No ☒

3. Are/Were you quarantined or have you been advised to self-isolate at home (by authorities/officials, a health care provider, medical staff or a medical advisor or by any other institution) or have you decided on your own to self-isolate yourself?

Yes ☐

No ☒

If yes, please advise about the reason for quarantine or self-isolation

4. Have you been diagnosed (based on a positive COVID-19 test result or based on your symptoms and your personal risk constellation) to have a proven or likely COVID-19 infection?

Yes ☐

No ☒

5. Did you ever have a COVID-19 test?

Yes ☐

No ☒

- If yes, was it negative (i.e. COVID-19 virus was not detected) or was it positive (i.e. you were found to have a COVID-19 infection)?

Please advise in detail on all testing dates and results.

- If no, is a COVID-19 test planned/recommended for you?

Yes ☐

No ☒

6. Do you currently suffer or did you suffer during the last 14 days from any of the following symptoms:

• Sore throat	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
• Runny nose	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
• Aches and pains	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
• Tiredness	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

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|---|------------------------------|--|
| • Fever of 38°C or above | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| • Cough | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| • Shortness of breath | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| • Difficulty breathing | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| • Persistent pressure or pain in your chest | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| • Bluish lips or face | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |
| • Confusion or inability to arouse | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> |

7. Have you been admitted to a hospital (or to any other kind of medical or public health institution/unit) whilst you have/had a COVID-19 infection or whilst you are/were suspected to have a possible COVID-19 infection?

Yes ☐

No ☒

If yes, please advise on exact admission period and location(s).

8. Do you work in an occupation where you have a higher risk to get in close contact with COVID-19 patients or with coronavirus contaminated material?

Yes ☐

No ☒

If yes, please advise about your exact occupational duties.

COMPANY NAME: CHIP Training and Consulting Pvt Ltd

PROPOSED MEMBER NAME : MEHWISH ALI

PROPOSED MEMBER SIGNATURE : Mehwish Ali

DATE: 16-September, 2021