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 ☐ No ☐
   - Runny nose — Yes ☐ No ☐
   - Aches and pains — Yes ☐ No ☐
   - Tiredness — Yes ☐ No ☐

- Fever of 38°C or above — Yes ☐ No ☐
- Cough — Yes ☐ No ☐
- Shortness of breath — Yes ☐ No ☐
- Difficulty breathing — Yes ☐ No ☐
- Persistent pressure or pain in your chest — Yes ☐ No ☐
- Bluish lips or face — Yes ☐ No ☐
- Confusion or inability to arouse — Yes ☐ No ☐

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 were 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.

PROPOSED MEMBER NAME : Muhammad Afzal

PROPOSED MEMBER SIGNATURE : Afzal

DATE: 17/10/24

17/10/24