**SELF-DECLARATION/SCREENING FROM FOR COVID-19 INFECTION**

**Name:**

**Age/Sex:**

**Address:**

**Mobile No: Residence No:**

**Email:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **COVID-19 QUESTIONNAIRE** | | | | |
|  |  | | **YES** | **NO** |
|  | **Do you have symptoms of fever, cough, screening, sore throat, fatigue, myalgia in the last 2 weeks** | |  |  |
|  | **Do you have difficulty in breathing?** | |  |  |
|  | **Have you travelled outside India in the past 45 days** | |  |  |
|  | **If yes, Mention the cities** |  | | |
|  | **Have you travelled outside or inside India in the past 15 days** | |  |  |
|  | **If yes, Mention the cities** |  | | |
|  | **Exposure to a COVID-19 Case or to suspicious patient in the last 3 weeks?** | |  |  |

* **The above information is true to the best of my knowledge. I understand withholding any information is unethical and against the interest of the Institution.**
* **All** Intern/Extern/JR with any positive history shall produce **Medical Certificate in prescribed format from Government Hospital Only. No Medical Certificate from Private Hospital/Practitioner will be accepted.**
* **I also agree to take care at all times my personal hygiene and care and report any matter that may be of concern to the Institution.**

**Date: Signature:**