COVID-19 (Coronavirus) Exposure Questionnaire for Health Care Workers[1]

[1] Health care Workers shall mean all registered health care professionals (doctors, nurses, allied health professionals including physiotherapists, pharmacists, phlebotomists etc.) involved in direct patient care

Name of the Proposed Insured/Proposed Owner:	
Policy/Application Number	
Occupation	
Medical Specialty (if applicable)	
Exact nature of duties (including procedural or non-procedural duties)	
Name and address of the medical facility you are working in	
Name of the Health Authority under which you are registered	

Please answer the following questions with as much detail as possible:

1. Have you been or do your work duties involve close contact with anyone who has been quarantined or who has been diagnosed with novel coronavirus (SARS-CoV-2/COVID-19)? If yes, please provide details including nature of work for patients with novel coronavirus (SARS-CoV-2/COVID-19).

   Yes ☐ No ☐

   _____

   _____

2. Have you ever been on leave of absence/sick leave due to a possible exposure of, tested positive or awaiting test results for novel coronavirus (SARS-CoV-2/COVID-19)? If yes, please provide relevant dates and details.

   Yes ☐ No ☐

   _____

   _____

3. Have you experienced any of the following symptoms within the last 14 days?

   - Any fever
   - Cough
   - Shortness of breath
   - Malaise (flu-like tiredness)
   - Rhinorrhea (mucus discharge from the nose)
   - Sore throat
   - Gastro-intestinal symptoms such as nausea, vomiting and/or diarrhea

   Yes ☐ No ☐

   If yes, to any of these, please indicate which and provide full information.

   _____

   _____

4. Are you currently in good health and actively at work?

   Yes ☐ No ☐

DECLARATION

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

Signed at _____ on this day _____ of _____ , _____

Applicant Signature

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