COVID -19 Screening Questionnaire

(Failure or refusal to accurately complete this form will result in you being denied entry onto TOFCO compound)

Company: _____

Name (Print): _____Date: _____ Telephone: _____

Address:_____

_____

Gender: Male ❑ Female ❑ Age: _____

Country of Citizenship: _____ Country of Residence: _____

1. Have you travelled outside of Trinidad within the last fourteen (14) days?
   Yes ❑ No ❑

   If yes, please list all the countries you have travelled to or disembarked at?

   _____

   _____

2. Do you have any of the following symptoms? (Tick if Yes to one or more)
   Fever ❑ Cough ❑ Runny Nose ❑ Sore throat ❑

   Headache ❑ Shortness of Breath ❑ General feeling of being unwell ❑

3. Have you been in contact or in close proximity (less than or equal to 2m) to a person exhibiting any of the symptoms above? Yes ❑ No ❑

4. Have you been in contact or in close proximity (less than or equal to 2m) to a person who has travelled internationally within the past fourteen (14) days?
   Yes ❑ No ❑

   If yes, what country/countries have you / they travelled to?

   _____

I hereby declare that the responses contained in this questionnaire are true and correct and agree to my immediate removal from the facility if found to be inaccurate.

Name (Print): _____Signature: _____